Nurses must guard against pain that can interfere with their work and take the pleasure out of their off-duty hours. Keep "217" Tablets readily available for fast protection when pain threatens or strikes. The handy tube fits conveniently in pocket or purse. The economy sizes of 40 and 100 tablets are ideal for home or office use.

Relieve

HEADACHES

NEURALGIA

RHEUMATIC PAIN

and COLDS

OUR 50TH ANNIVERSARY YEAR

Charles E. Frosst & Co.
MONTREAL CANADA

Between Ourselves

It is many months since we have devoted an issue to the problem of **Mental Health.** There are so many different aspects that could be included that it was difficult to decide what to eliminate. The fare that is provided here discusses the problem of the nurse in dealing with patients in their homes, in the community, in hospitals.

Mrs. Russell's *discussion shows* the psychological difficulties that may develop in any type of illness. We are very grateful to *California's Health*, the bulletin of the State Department of Public Health in California, for permission to reprint this valuable material.

Saskatchewan has taken a long stride forward in the attention they are giving to this phase of health work in their public health program. **Dr. McKerracher** and **Mrs. Closs** are very familiar with all of it. **Miss McClure** describes the developments in Alberta along the same line.

Dr. Baltzan's *article indicates* the seriousness of the problem of mental illness. **Miss Ogilvie** and **Miss Hutchison** point out the gaps in the regular course in instruction and training that is presently available to student nurses in Canada.

Finally, **Miss Cole** *and* **Miss Juleff** *have written* case histories of actual patients with psychiatric difficulties.

About the only general aspect that has not been included is *ourselves.* What of our own mental health—our ability to adjust to new or unusual circumstances?

We have all seen a man swinging along on a crutch. A leg in a cast is proof he has been injured. The crutch enables him to get around without hurting himself further. People accept him and his injury and willingly give him a helping hand if he needs it. The chances are he will be quite independent about it. The crutch is a badge of honorable injury. Later he may swap it for a cane. It, too, is a good thing to lean on.

There are all kinds of crutches for getting along in life. We all take our bumps and bruises and, when you stop to think of it, many of them are of the spirit rather than the flesh. Things like feeling hurt, like grief and anger, fear and guilt.

When we feel hurt and uncomfortable, or merely have a dread that we will be, a lot of us start fumbling for a crutch. Any socially acceptable way of favoring the sore spot will do. Some of us use the "goldbricking" crutch now and then. We do it more or less automatically and instinctively. We get tense and nervous and use the physical symptoms arising from this tension to get out of facing our responsibilities.

It is not easy to throw away our crutches and risk the pain of give and take with the head nurse, our friends, our family. But it is a real satisfaction to succeed in our work without endless need of support. Of course, we all need a little help on occasion. We all have an itch to use some kind of crutch—or at least to carry a cane that we can lean on when the going is rugged.

Let us go over our own actions now at year's end. Are there some crutches we can throw away forever? Can we be more self-reliant, more dependable, more responsible in the New Year?

* * *

In keeping with the theme of this month's issue, our **cover picture** is a winter scene taken at the Provincial Mental Hospital, Ponoka, Alta. It is a beautiful landscape at all seasons of the year, particularly so when the sun sparkles on the snow.

* * *

Almost every position that is advertised in our *Journal* carries the message that statutory holidays are recognized and a time allowance, with pay, is made for them. That means that most of us will be enjoying free time in the next few weeks as we all celebrate Christmas and New Year's. To each of you, we at the *Journal's* offices send hearty greetings for—

A MERRY CHRISTMAS
and
A HAPPY NEW YEAR!

YEAR'S END—
Out of the strain of the doing,
Into the peace of the done.
—WOODRUFF

in Rheumatic Fever

"in 34 cases (of acute rheumatic polyarthritis) . . . the therapeutic response was more dramatic . . . than in any other of the categories of arthritis studied . . . all evidence of rheumatic activity disappeared within fourteen days . . ."*

AND IN 17 CASES OF ACUTE INFECTIOUS ARTHRITIS . . .

"all cases improved promptly . . . fever subsided on the average in three days with disappearance of pain and tenderness on the fifth day . . . all evidence of arthritic activity disappeared within ten days . . . in no case was it necessary to continue treatment beyond a period of two weeks."*

BEREX (*oral*) *Therapy relieves pain promptly*
BEREX *tends to restore normal physiological action*
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BEREX *is* NON-TOXIC
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BEREX *is* NON-TOXIC
BEREX *Therapy is low in cost*
BEREX *is the only* TESTED *Succinate-Salicylate product*

BEREX therapy is indicated in Osteoarthritis, Rheumatoid Arthritis, Sciatica and Arthritic Neuritis . . .

BIBLIOGRAPHY: Ohio State Medical Journal, Oct. 1947; J.A.M.A., 135:1114 (Dec. 20, 1947)
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Professional literature and a reprint of the article,
*"SUCCINATE-SALICYLATE THERAPY IN ARTHRITIS" on request to

BEREX Pharmacal Company, 36-48 Caledonia Road, Toronto, Canada

New Products

Edited by **PROFESSOR F. N. HUGHES**

PUBLISHED THROUGH COURTESY OF *Canadian Pharmaceutical Journal*

SALUNDEK OINTMENT

Manufacturer—Wallace & Tiernan Products, Inc.; Canadian distributor: Vanzant & Co., Toronto.

Description—Contains undecylenic acid 25%, salicylanilide 5%, in a carbowax base with added wetting agent to improve penetration.

Indications—For treatment of superficial fungous infections of the skin, hairy parts especially.

CICOLINE SYRUP

Manufacturer—Barlow-Maney Laboratories, Inc., Cedar Rapids, Iowa; Canadian distributor: Biomedicals Ltd., Hamilton.

Description—Each 5 cc. of palatable syrup represents 1.25 gm. choline dihydrogen citrate.

Indications—Treatment of conditions resulting in cirrhosis of the liver; liver damage resulting from malnutrition or systemic infection.

VENOTUBE (Disposable Infusion Unit)

Manufacturer—Abbott Laboratories Limited, Montreal.

Description—A disposable infusion unit for Pentothal Sodium administration. Sterile unit containing plastic tubing with attached male and female Luer adapters and disposable pinch clamp. Provides convenient flexible connection between syringe containing Pentothal Sodium solution and injection needle.

CECON Dulcet Tablets

Manufacturer—Abbott Laboratories Limited, Montreal.

Description—Each orange-flavored Dulcet tablet represents ascorbic acid 50 mg. (Vitamin C, 1000 I.U.)

Indications—Where vitamin C supplements are indicated.

SOMAGEN—Solubilized

Manufacturer—The Upjohn Company, Toronto.

Description—Palatable, fortified, readily digestible whole protein. Each 100 gm. contains protein 70 gm., carbohydrate 22 gm., yeast extract from 15 gm. yeast, liver concentrate from 45 gm. whole liver.

Each gram has been supplemented to present approximately: Thiamine hydrochloride 0.05 mg., riboflavin 0.05 mg., pyridoxine hydrochloride 0.02 mg., calcium d-pantothenate 0.10 mg., nicotinamide 0.30 mg., folic acid 0.02 mg.

Indications—Conditions where supplements of easily digested protein and B vitamins are indicated.

AMOTRICIN Lozenges

Manufacturer—McNeil Laboratories, Inc., Philadelphia; Canadian distributor: Vanzant & Co., Toronto.

Description—Each flavored lozenge (colored orange) contains: Tyrothricin 1 mg., cetyl dimethyl benzyl ammonium chloride 5 mg., orthesin (Benzocaine, McNeil) 3.5 mg.

Indications—Throat irritation and infections, especially if due to gram-positive cocci.

Cream NEOHETRAMINE Hydrochloride 2%

Manufacturer—John Wyeth & Bro. (Canada) Limited, Walkerville, Ont.

Description—2% of Neohetramine (Nepera brand of Thonzylamine-N, N-dimethyl-N'-p-methoxybenzyl-N'-(2-pyrimidyl) ethylenediamine monohydrochloride) in a cream base.

Indications—For topical application in the treatment of skin affections of an allergic nature, such as contact dermatitis, atopic dermatitis, pruritus ani et vulvae, drug allergy, lichen simplex, eczematoid dermatitis, insect bites. Sometimes used to supplement oral treatment with Neohetramine.

Administration—Rub cream gently into affected areas 3 or 4 times daily.

SEVINON, Oral Undecylenic Acid

Manufacturer—Schering Corporation Limited, Montreal.

Description—Each soft elastic capsule contains 0.44 gm. of especially purified undecylenic acid.

Indications—May be of value in psoriasis, neurodermatitis, arthritis, bursitis, tinea capitis.

Administration—At meal-time, in doses as prescribed. Until more is known about its metabolism, should be given with caution. If high doses given over prolonged period weekly blood counts and urinalyses are advised. Should not be given to debilitated patients, those with coronary or gall-bladder symptoms, or to diabetics.

BUTISOL SODIUM

Manufacturer—McNeil Laboratories, Inc., Philadelphia; Canadian distributor: Vanzant & Co., Toronto.

Description—Sodium 5-thyl-sec. butyl barbiturate in scored tablets of ¼ gr. (colored lavender), ½ gr. (green), ¾ gr. (orange), 1½ gr. (pink). Capsules of 1½ gr. (lavender). Peppermint flavored elixir contains 3 gr. per fl. oz.

Indications—Conditions wherein an intermediate sedative or hypnotic is indicated, such as: daytime sedation, insomnia, neuroses, pre-operative apprehension, etc.

SORPARIN TABLETS

Manufacturer—McNeil Laboratories, Inc., Philadelphia; Canadian distributor: Vanzant & Co., Toronto.

Description—An alcoholic extract of berries of the European mountain ash (Sorbus aucuparia). Each pink sugarcoated tablet contains 3 gr. of the dried extract.

Indications—Hepatitis, post-surgical biliary syndrome, idiopathic hypoprothrombinemia, and milk liver dysfunction secondary to chronic cholecystitis.

Chocolate-Flavored Milk

Recent discussions regarding the nutritive value of this product have suggested that there are some potent arguments against its use, especially for children. It is stated that skimmed milk is used which, with the loss of the butter fat, contains a minimum of vitamin A. There is sugar added which brings the caloric value above that of whole milk. The most serious objection appears to be the fact that the tannic and oxalic acid, which cocoa contains, lessen the calcium retention in the body and impair the child's appetite. Moreover, theobromine, which is also present, is a stimulant.

Actually, the amount of cocoa used in producing this beverage is not sufficient to cause any demonstrably injurious effect upon the calcium metabolism in humans nor does the small amount of theobromine have much stimulating effect.

Dentists tell us that the considerable amount of extra sugar is undesirable because of its action in promoting dental decay. Those children who are finicky eaters at the best of times seem to lose their appetites for other foods, particularly if this milk is consumed during the mid-morning recess. This is true if any food or beverage is taken too soon before the next meal.

—*South African Nursing Journal*

especially for them.

... its citrus-like flavor and odor

hide six essential vitamins

Each tasty, 5-cc. teaspoonful of Vi-Daylin contains the minimum daily requirement of vitamin A for a child 1 to 12, twice the minimum daily requirements of vitamins C, D and thiamine, and supplemental amounts of riboflavin and nicotinamide. Vi-Daylin administers from the spoon, mixes readily with cereal, juices or baby's formula. It is stable at room temperature for two years, won't stain clothing, won't curdle milk, leaves no fishy after-odor. Children and finicky oldsters love it. Available in bottles of 90 cc., and 8 fluid ounces. Abbott Laboratories Limited, Montreal.

Abbott

VI-DAYLIN
TRADE MARK

(Homogenized Mixture of Vitamins A, D, B_1, B_2, C and Nicotinamide, Abbott)

49-82

The
CANADIAN NURSE

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PUBLISHED BY THE CANADIAN NURSES' ASSOCIATION

VOLUME FORTY-FIVE *NUMBER TWELVE*

MONTREAL, DECEMBER, 1949

Some Christmas Thoughts

Average reading time — 2 min. 24 sec.

Preparing an editorial for the December issue as far in advance as our publication dates necessitate, it is difficult to capture a glimmer of the excitement, the sights and sounds of this happiest of seasons. We thought we might paraphrase what we have been saying for years but somehow we wanted something new and different. A season that brings so much of relaxing, rejoicing, and remembering merits thoughtful consideration editorially, just as one gives thoughtful care to the selection of one's gifts to special friends.

We pondered on this matter for some time then suddenly we asked ourselves—why something new, anyway? The message of Christmas has rung out as a clarion call for 2,000 years: why should it not inspire us all today?

This is the season of great human generosity and high resolve. For centuries, long before the Christian era, men observed a mid-winter festival symbolizing their refusal to submit to the death that lurked in the freezing cold and the lack of growing things to supply them with food. For all of us today the message of Christmas means somewhat the same thing—a festival when we accept and recognize the brotherhood of mankind.

We give proof of our essential worth and goodness in the openness of our hospitality and the giving and receiving of gifts. The resounding truth that it is more blessed to give than to receive becomes more apparent to each of us as we gain in years and experience. This year we need to give *ourselves* the greatest gift of all.

It is not too difficult seemingly to shut our eyes to the ills of the world and the interminable problems that confront us. True, we are thankful for the better things of life that are ours for the taking. Unfortunately, many of us have lost the vision of what the world could be like if the message of Christmas were a living, vital reality to everyone. We must recapture that vision, not just in the high hopes of Christmas and the sincere purpose of New Year's, but in our everyday living all year long. We must recapture our reliance on the ability of our own mental powers to solve problems. We must marshall our moral dignity against the forces

of darkness. To achieve these highest of human aims, we need *self-confidence and self-discipline.* These are the gifts we should give ourselves this year. Then we would have a true appreciation of the spiritual values of our work. We might even be able to cherish a year-round spirit of Christmas. If this were possible for us individually, harmony and achievement in the world about us would follow.

And so as 1949 draws to a close, we thank you for all your loyal support. Though our professional ranks have been depleted by those who have retired, and those who have gone to rest, new minds are ready to pick up the tasks. To each of you, a happy, heart-warming Christmas. And may the message of peace on earth, goodwill towards men stir us to new resolves.

HAPPY CHRISTMAS!

In the Good Old Days

(The Canadian Nurse, December, 1909)

"There is no class of women workers so highly paid as nurses. There are, of course, some exceptions, but as a class nurses can command higher pay than other women, in consequence of which, the public expects, and has a right to get, a proportionately high class of service. The nurse who works only for the money is never going to satisfy the patient that she has given service equal to the remuneration demanded."

* * *

"In medical work the place where a nurse may shirk, if she is so inclined, is in her powers of observation. The greatest hindrance to observation is the lack of concentration of the mind upon the matter in hand. The nurse cannot cultivate this power to too high a degree."

* * *

"The Victorian Order work in Toronto has increased rapidly, August being a busy month with 982 visits."

* * *

"Following the graduation exercises, the new graduates each received a $20 gold piece—the usual parting gift of the Board of Governors."

* * *

" 'Secret Remedies,' published for the nominal cost of one shilling by the British Medical Association, is a book that no doctor or nurse can afford to do without. It tells what these cheats cost and what they contain."

* * *

"Our grateful thanks to the Alumnae Association for their kindness in meeting our much-felt need for a magic lantern."

Cumulative Index

Early in the New Year, the first two volumes of the Cumulative Index of the material that has been published in *The Canadian Nurse* from January, 1940, to December, 1949, will be available for distribution. To facilitate reference, this material is being indexed in five-year periods as far back as 1935; for the preceding years, a ten-year period will be contained in each volume. Eventually we will have six volumes ready—1905-14, 1915-24, 1925-34, 1935-39, 1940-44, 1945-49.

This will be the first time that most of the material in earlier issues has been indexed. While we all realize that there is much that is out of date by our present standards, the stories of events and developments in nursing through the years presents a fascinating picture. Through the Cumulative Index this material is now collected under suitable headings for easy reference.

Because of the high cost that would be involved if all of this material were printed, it is being prepared in mimeographed form and will be bound in loose-leaf folders for convenience in use. It will be available to libraries in our nursing association offices, schools of nursing, hospitals, universities, public health organizations community nursing registries, and private individuals at the very nominal cost of **One Dollar per Volume.** So that we may have some idea of the number of copies that should be prepared, we ask your co-operation in placing your order as soon as possible. The *Journal* address is *Suite 522, 1538 Sherbrooke St. W., Montreal 25, Que.*

The Nurse, the Patient, and Emotions

MARION E. RUSSELL

Average reading time — 11 min. 6 sec.

EVERY physically ill person is potentially an emotionally upset person. Some fear and anxiety are associated with every illness.

The interrelating influences of physical, emotional, and social factors in illness and in health are receiving increasing recognition in medicine. In the past few years we have developed increasing understanding of the psychoneuroses as well as of the emotional components in the behavior of the so-called normal person. We have seen more clearly that concentration solely on the physical condition of a person does not necessarily ensure recovery despite the best of medical care; that discouragement, anxiety, fear, uncertainty, dependency, and secondary gain also influence the physical health of a person. We have seen how patients, after repeated tests and treatments and operations, develop symptoms which are not accounted for by medical findings. After repeated unsatisfactory medical experiences, an underlying deep anxiety is occasionally stirred up in a patient to the extent that he is controlled by his worries about his health. We have heard of patients in whom a relatively unimportant injury has released emotional outbursts and difficulties which were previously latent, but which became crippling when not treated with sympathy, insight, and skill.

Fortunately, it is becoming less common to divide the patient hypothetically into physical and emotional entities—to consider that he either has an actual organic difficulty or is psychoneurotic. We know now that anyone who complains actually does have something the matter, regardless of the cause; that the symptoms of an emotional illness are not imagined ones, but are painful and undeniable to the patient.

With the recognition that every illness is both organic and functional, a wealth of potential service has opened up to the nurse. Bedside nursing no longer means primarily bed-baths and treatments; it means, also, constant alertness to the expressions of thinking and behavior which show how this patient is reacting to his illness and knowledge of how these reactions can be used in a way to further his progress. Although every illness expresses the interaction of physical, emotional, and social forces, in one patient the organic forces will predominate and in another the emotional, depending on the pressure of the factors involved. Since the nurse has extensive contact with a patient at a period when he feels helpless and when his defences are down, she meets reactions which he ordinarily covers up, and is in a position to see where he might be helped. A patient who does not appear emotionally disturbed may actually be able to face his illness with the kind of strength that will help him get back on his feet expeditiously. On the other hand, such a bland or cheerful appearance may show the patient's way of reacting to difficulties, denying them by covering up. The basic discouragement of this type of patient will eventually show itself in little ways—in attitudes or gestures or comments which reveal that if he could only talk about his situation and be helped to see and face the reality in it, his convalescence could be shortened. The use or misuse of opportunities to work with what the patient feels determines to a noteworthy extent the progress of our efforts to help him recover.

The nurse may occasionally have the care of a patient in whom no organic findings substantiate his complaints and whose symptoms are,

Mrs. Russell is a psychiatric social worker with the California State Department of Mental Hygiene.

therefore, assumed to be of an emotional nature. If, in this absence of demonstrable illness, the nurse gets the feeling that the patient's incapacitation or pains are not real, she may use the doctor's diagnosis in a punitive way and make demands or claims which only add to the patient's pains and anxiety. Aside from performing her tasks, she can actually remove the patient from any assistance connected with her by an unsympathetic attitude which adds to his resistance.

The superficial attitude of the patient to the nurse is determined to a large extent by her interest in winning his confidence, her sincerity, and her capacity to help him. However, the patient's response to the nurse is also determined by factors which are not at all apparent: by his experience in the past in similar situations of helplessness, by past dependence on someone who had the responsibility of taking care of him, and the power to get around while he himself was confined to a small space. The patient is bound to transfer to the nurse his feelings about the person who took care of him in an earlier helpless situation. Indeed, these earlier experiences and his feelings about them are the very things that set the tone for his responses in his present helpless situation. And these predetermined reactions to the nurse can be modified one way or another by her understanding and acceptance of them and her way of responding to them.

It is common for patients to develop a strong feeling for a certain nurse, often a night nurse, without anything in the objective situation that would make this feeling warranted. The night nurse is perhaps most often the recipient of strong feelings because the patient is more alone at night and feels more receptive to whatever contacts come his way; his underlying feelings come to the fore. She not only is the only one who gives him personal care and attention, but she is the sole person to be observed and speculated about; she has the advantage of being ambulatory when he is confined. In his isolation he attaches to her the kind of importance and feeling he has for the person who helped him when he was helpless earlier. Although this transfer of emotions is seen frequently in patients in hospitals, the same mechanism functions in well people also, but is often less easily recognized because of various factors which divert and modify its expression.

The Nurse as a Therapist

Because of this relationship intrinsic in the situation the nurse becomes unwittingly and to some extent a therapist, someone whose most ordinary duties and most casual speech assume a value which is out of proportion to the actual situation, heavily weighted by the patient's unknown earlier-determined feelings about her. The physically ill person is an especially susceptible carrier of feelings connected with previous situations which have similarity to the present one. Because of this, the way the nurse builds into the patient's feelings or helps modify them by her conversation, activities, and approaches becomes particularly important in accelerating or retarding recovery.

The feelings of love, or hate, or anxiety, or fear, or guilt, which the patient expresses toward the nurse, may make her, in turn, feel helpless, since they have an unpredictable quality. The patient is apt to express his love for the nurse in terms of dependence and over-obedience—his hate in terms of disobedience and touchiness. If the nurse has insight into how the patient's emotions are being displaced from a previous situation to the current one, she can handle his behavior tolerantly and helpfully. She will then continue to be accepting of the patient, regardless of his behavior. The goal in working with him is to be consistently sensitive to his needs, cautious yet spontaneous, respectful (as one appreciative human being to another) and alertly considerate.

If the nurse does not understand

the over-emotional reactions of the patient, but rather feels maternal and reacts simply to his behavior, she is apt to respond to his over-obedience by praising him and preferring him to less obedient patients. Thus she encourages him to be more obedient in his need for her praise and deprives him of the initiative and the griping which could actually be more beneficial to his progress. On the other hand, a nurse may not like to have a patient depend on her and be over-obedient, but may be afraid of being involved in a maternal role. If so, she will "professionally" discourage the patient from leaning so much on her and will be so impersonal and brief with him that he, in turn, may be thrown into more complicated emotions arising from perplexity over the nurse's change in attitude.

To some extent the nurse is caught in a dilemma. On the one hand, concentration on the emotional and social components of illness naturally brings about resentment in a medical staff absorbed and busy with physical tests and treatments. On the other hand, ignoring the emotional and social components of illness adds burdensome and often unnecessary physical examinations, laboratory tests, and surgical operations. Between these extremes, the nurse can be of help to both the doctor and the patient so long as she does not become aggressive in her concern with emotional and social problems. She is in an advantageous position to help the patient in his relation to his doctor, who also represents emotionally great power to the patient and who, therefore, is invested with all the hopes and frustrations attached to a powerful figure. She can help the patient understand what the doctor has actually said and is really trying to do for him.

At times a patient appears uncooperative and goes counter to a doctor's orders. Such "unco-operativeness" may simply mean that the patient is unable to accept the medical information, since what he thinks it involves is intolerable to him. Further, it is sometimes difficult for him to be co-operative when the nurses and doctors know secrets about him which they keep from him in compliance with professional ethics. Their knowledge is sometimes protected in a "professional" way by "I don't know . . . " which can be very frustrating to a patient. In order to change him into a co-operative patient it is necessary to understand how to interpret the medical information in a way that will make the situation tolerable to him. In his thinking there is often a bizarre misunderstanding due to his noncomprehension of medical terms and of what is involved in them. Some of this misunderstanding and not-knowing is due to lack of opportunity of the patient to know. But some misunderstanding and lack of information are due instead to lack of readiness of the patient to accept available information because of past experiences that make him want to sidetrack the facts. If the nurse can pass her observations on to the doctor, she can help him use the patient's attitudes both toward medical care and toward himself in a progressively helpful way. Doctors as well as others vary, of course, in their ability to "take" the antagonisms and frustrations of patients. The nurse learns to gauge her information to the tolerance of the recipient.

Skilful Handling

All acute feelings of the patient can provoke comparable or opposite feelings in the person who does not understand their meaning. By skilful handling of the situation, the nurse can give current grounds to the already displaced attitudes of the patient or can help modify them. It helps decrease our own involved emotions if we ask ourselves why the patient is so difficult, find a logical answer in terms of the patient's probable experience, and then act accordingly.

In spite of most thorough technical training the nurse cannot help being thrown into an emotional turmoil of conflicting attitudes and feelings be-

cause of forces outside herself—of external difficulties which find a deep, though perhaps unrealized, response in her own attitudes and emotions. Interestingly, she herself is often obedient in a displaced kind of way. In her job, obedience to orders is an intrinsic part of her functioning. She cannot express disobedience but can be over-obedient. Over-obedience to orders can often cover some real feeling of dislike or punishment to a patient, to a doctor who has written the orders, to an agency which enforces them, or even to herself for being in a situation she does not like.

For a large proportion of a working day the nurse is expected by most people to be dependable in tact, accuracy, and function and to be uncomplaining, patient, and cheerful, while at the same time self-effacing. These are perfectionist, better-than-human standards. The nurse, however, has the same human problems and difficulties as the patient. Not every patient is the right kind of person for the abilities of a particular nurse. The hospital or agency cannot allocate patients according to a nurse's ability to work well with certain types of people. The only way to avoid maternalism, anger, indifference, contempt, or punishing behavior is to acquire insight into the reasons why we ourselves tend to feel and react in certain patterns as well as to try to understand the behavior of our patients. We must know the kinds of people we work with best, and why we do not work so well with others, in order to increase our usefulness with all people.

What we do and say, how we interpret a patient's reactions, depend on how well we are adjusted or how severe, aggressive, dependent, or indifferent we are. Without words, hidden attitudes make themselves felt and become decisive in the response of patients. Some people are intuitively helpful with patients. But helpfulness is a learned skill also; by learning to understand ourselves better we can increase the varieties of people and problems we can work with skilfully.

Notice of Publication

A 16-page booklet—"Arthritis—Plan for Attack"—has been published by the Canadian Arthritis and Rheumatism Society recently. Prepared with the advice and approval of the society's Medical Advisory Board, the booklet will be of interest to many members of the nursing profession.

The pamphlet is concerned with the problem of rheumatic diseases in Canada, a plan for a concerted attack upon them is presented, and the role of the Canadian Arthritis and Rheumatism Society is discussed. An extract from the booklet's preface indicates the general nature of the society's approach to this problem: "In preparing this Plan, the Canadian Arthritis and Rheumatism Society has been deeply conscious of the magnitude of the problem which arthritis presents. It has been equally aware that a very great deal can be done, to relieve both the suffering of individuals, and the present drain on the nation's economy.

"It is also recognized that a plan of attack on arthritis can be carried out only through the effective co-operation, interest, and participation of many agencies and groups, notably the medical profession, health and hospital authorities, medical schools, and the general public. The Plan herein proposed discusses the role of such groups in a co-ordinated attack, and describes the society's own position in relation thereto as but one active part of a greater whole."

Copies are available free from the *Canadian Arthritis and Rheumatism Society, 74 Sparks St., Ottawa.*

As a person grows older he usually becomes less active and has less need for energy foods. But he still needs the same amount of foods containing vitamins, minerals, and proteins. The elderly person needs foods that are easily digested and some senior citizens get along better on smaller meals with mid-morning and mid-afternoon snacks.

The Public Health Nurse in a Mental Hygiene Program

D. G. McKERRACHER, M.D.

Average reading time — 7 min. 36 sec.

THE PRESSING NEED for vast expansion in the community mental health services is evident to all who are interested in health. In the past, the mental hospital has been the chief, and in some instances the only, centre of provincial psychiatric services. This service has, unfortunately, too often been limited to the area within the hospital walls. In the past the hospital has been unable to function adequately in the community, either in regard to the prevention of mental disorder or even in the follow-up of discharged convalescent psychiatric patients. Accordingly, the first great requirement is that the hospital be furnished with an arm in the community.

An equally disturbing deficiency is the lack of organized effort to carry out a preventive program in respect to mental disorder. When one notes the heavy toll in any community, resulting from intellectual, emotional, and behavior aberrations, one becomes aware of the necessity for organized action. One has only to glance at Canada's record of psychiatric morbidity to comprehend this need. There are 50,000 patients in mental hospitals, and 11,000 inmates in goals, reformatories, and penitentiaries. Tens of thousands of people annually require help from physicians because of symptoms based principally on unresolved fears and frustrations. When one adds to this total the score of faulty inter-personal relationships in home and occupational organizations, resulting from personality maladjustments, the seriousness of the situation becomes only too clear.

Dr. McKerracher is Commissioner of Mental Health Services with the Saskatchewan Department of Public Health.

In the face of this community need, the Division of Mental Services of the Department of Public Health in the province of Saskatchewan undertook in January, 1947, the development of a mental hygiene program. It was felt that an organization should be set up to facilitate communication between the mental hospitals and the community and to undertake procedures aimed at the prevention and amelioration of mental disorder. The principle immediate obstacles to hurdle were:

1. The necessity for obtaining psychiatrists to organize and administer such a service.
2. The need for community workers to carry out the functions of this organized plan.

The first difficulty was met by making use of mental hospital psychiatrists on a part-time basis. In an attempt to solve the second difficulty, we sought and secured the co-operation of the provincial public health nurses.

The tentative plan was discussed with the director of the Division of Public Health Nursing and then with the newly appointed director of Health Regions. Arrangements were made for all the public health nurses, both in Regions and areas where Regions had not been organized, to receive mental hygiene training. Training courses of one month's duration were set up at the Saskatchewan Hospital, Weyburn, and the Saskatchewan Hospital, North Battleford. During the 15 months subsequent to the commencement of this program, about 60 public health nurses received this one month's training.

The goal of this course was to give the public health nurse not only an understanding in the field of psychiatry but also useful techniques which

she might employ. Accordingly, the course provided not only teaching, lectures, and seminars, but also practical experience in the nature of investigation and therapy with patients, under the supervision of competent psychiatrists. It would seem unnecessary to mention that no one considered one month's training to be sufficient to give the nurse professional competence in this field; however, it was intended to give her an orientation and grounding which would be the basis for further in-service training.

With this psychiatrically oriented group of public health nurses available to co-operate with the community program, the mental hygiene service began to take form. A close working relationship was established between the public health nurses and the mental hospitals. The public health nurses secure required information from individuals located in their community, concerning patients who have been admitted to mental hospitals, as well as those who have entered the Saskatchewan Training School for the mentally retarded.

When the superintendent has any doubts about the suitability of the home of a patient whom he wishes to discharge, the public health nurse carries out a pre-discharge investigation and the hospital decision is based, to a considerable extent, upon these findings. Following the discharge of patients, public health nurses are notified through the director of public health nursing or the Regional health officer, and perform periodic follow-up services—visiting the patients at home, advising the relatives, and notifying the hospitals concerning progress.

In the preventive field the public health nurses are proving most interested and helpful. Four provincial mental health clinics, chiefly on a part-time basis, have been set up and several more are contemplated. The function of these clinics is to provide consultation service to the practising physician and training in the principles of mental hygiene to those people in the community whose responsibilities link them closely with the problems of mental health. This latter group is comprised principally of parents and teachers. Whenever patients have been referred by the practising physicians through the Regional Health Units to the mental health clinic, the public health nurses have been invaluable in collecting information and helping to carry out therapeutic recommendations, under the guidance of the director of the mental health clinic.

Child guidance service, associated with the schools, has been developing at Weyburn and Moose Jaw. In these centres, the nurses at the Regional Health Unit function as school nurses. Accordingly, they are available for the discussion of classroom mental hygiene problems with teachers and teacher-psychologists. When one of the teachers or the teacher-psychologist wishes to refer a child to the mental health clinic, the public health nurse carries out a home investigation and prepares a detailed history. She presents this history at the regular conference conducted by the director of the clinic. This conference is essentially a teaching conference, the object of which is to give school teachers greater insight and understanding concerning the mental health problems of children. This conference is attended not only by the nurses of the Health Region but also by the teacher-psychologist, the school principal, and interested teachers. This project recognizes the very great importance of the teacher in the prevention of mental disorders.

Quite apart from the activities which are specifically of a mental hygiene nature, the public health nurse utilizes her mental health training in the course of all her duties. It is felt that the insight she gains from this experience gives her more understanding concerning the emotional reactions of individuals and their families who are the object of such health activities as tuberculosis or venereal disease control and the prevention of communicable diseases. It is felt that the techniques which public health nurses are learning,

with respect to influencing the behavior of individuals, will increase their efficiency in carrying out non-psychiatric public health programs. Finally, in the course of their regular duties, public health nurses are frequently called upon to discuss and advise about personality problems with parents and relatives.

Our experience with the public health nurse as an integral part of the mental hygiene program has been a satisfactory one indeed. She has brought to this partnership a co-operative willingness plus insight and good common sense. Her prestige with the community has been most important in obtaining recognition for the relatively new public health function of mental hygiene.

Learning by Doing

D. R. Closs

Average reading time — 4 min. 6 sec.

The Health Region in Moose Jaw, until July of 1947, was busily engaged in an ever-broadening field of preventive medicine consisting chiefly of school inspection and immunization for infant, pre-school, and school children. Then the possibility of including a mental hygiene clinic in our program was discussed. This would provide a most important and much needed, although now sadly neglected, side to our work.

We were faced with a problem—we were not properly trained to participate in such a service. The answer was a month's psychiatric course in mental hygiene. This course was open primarily to public health nurses, social workers, and teachers. While taking the course we lived in residence at the hospital where there was any amount of literature at our disposal. We spent our days attending lectures and seminars conducted by competent psychiatrists. We were taken through the various wards and occupational therapy departments of the hospital. We realized more every day how little we could learn of such a large subject in one short month. However, we spent considerable time on the wards where, throughout the month, we were each assigned three or four patients to interview, putting into effect to the best of our ability the techniques we had been taught. We grasped the fundamentals of the problem and gained an earnest desire to continue our education. When we had completed our first history we were required to present it to the group where discussion, under the capable direction of the psychiatrist, brought out more clearly the significance of the information we had obtained and showed us phases we should have investigated but had frequently missed entirely. In this manner, by the time we had completed three or four such histories, we were doing a reasonably good job. We were understanding the work enough to make us really interested and hungry for further knowledge which would come with our experiences in the field and constant study.

During the course we attended the conferences where a specific patient's care was presented by the doctor in charge. The patient was brought in and interviewed by the hospital's entire staff who, after consultation, decided on diagnosis and a course of treatment. We were able, under the direction of a psychiatrist, to observe and discuss the different forms of treatment used.

After learning these things and seeing the large number of mentally ill people in only one of the hospitals,

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we began to realize that maladjustments usually resulted from wrongly influenced behavior. We could see that many of these tragedies could be prevented if there were a more widespread understanding of the fundamentals of mental hygiene.

Soon we had our first opportunity to be of assistance in a mental hygiene clinic. Each clinic day a problem child, from one of our schools, with the parents are seen in the morning. Adult patients, referred by the private practitioners, are interviewed by the psychiatrist in the afternoon. The public health nurse obtains and compiles suitable information regarding each case—child or adult—before the psychiatrist arrives. In the late afternoon, after the psychiatrist has interviewed the school child and the parents of that child, a conference—including the guidance officer, the school principal, teachers, public health nurses, and Regional Medical Health Officer—is conducted by the psychiatrist in our clinic. He invites a better understanding by the group, not only of the one particular individual under discussion, but of the behavior of all children. By combining our efforts we have been able to provide a good enough picture to enable the psychiatrist to suggest and discuss a suitable course of action.

We are advised also as to a suitable course of follow-up visits for the adults who have been interviewed. In most of our visits we receive a warm welcome, and we have had some very gratifying results in better adjustments and markedly improved mental attitudes.

We are acquiring an ever-increasing case load of persons sent home from hospital on probation. We pay routine visits to these people and offer any assistance we can. Often this amounts merely to paying a genuinely interested, friendly, and reassuring visit. Reports are made by way of the Regional Medical Health Officer to the hospital regarding the patient's adjustment to society and the home.

Lastly, we are sometimes called upon to carry out pre-discharge home investigations. Using the knowledge gained during our course, we try to evaluate the home situation in such a manner as will assist the hospital in determining the advisability of permitting the patient to return home. An effort is made to help the members of the home understand their responsibility in the patient's adjustment.

As a public health nurse, I feel we have profited immensely from the course in mental hygiene in our everyday public health work. We are able to understand, in a more sympathetic way, the greatly varied and sometimes difficult personalities and behavior with which we come in contact. We feel more capable and effective and can more easily carry out the different aspects of our work.

Hot Fomentations

Fill a deep cooking utensil with about two inches of water. A colander which fits into the pot, but does not reach the depth of the water, should be placed there to hold the towels. Then soak two small bath towels in hot water and wring them as dry as possible. Place them in the colander and cover with a lid. Bath towels become very hot from the emerging steam, but do not have to be wrung out. Consequently, there need be no burnt hands. One towel is applied while the other is heating.

With this method, towels are much hotter when applied to the patient. The procedure is ordinarily safe. Skin sensitivity varies, however, and the precaution of testing the towel to avoid burning the patient should never be omitted.

—*M.L.I.C. Quarterly Bulletin*

What's in an egg? The answer is good flavor plus high food value. A single egg contains proteins, fats, iron, phosphorus, calcium, and vitamin A. Eggs are easy to cook, can be served in countless ways, and are an easily digested food for young and old. Nutritionists say we should eat eggs at least three times a week.

Private Duty Nursing

Mental Aspects of Patients

D. M. BALTZAN, M.D., F.R.C.P. (C)

Average reading time — 14 min. 24 sec.

RESPONSIBLE medical care of an individual must recognize to the fullest extent the normal qualities of the "mind," abnormal deviations, the unity of psyche and soma, the influence of environment, and wonder, at least, about cosmic relationships. This broad view is a modern prerequisite of the physician and nurse. To them it is infinitely more vital in the performance of their duties than other workers in the realm of the social services.

The "mind" or psyche is a collective designation of numerous activities. The brain is not an isolated organ. It is the "grand central" of a complex system for decodifying stimuli and co-ordinating messages within the organism. The highest point of development is the faculty of abstract thinking, which is the level of intelligence. At this point the qualities of the mind or psyche are so phenomenal as to be conceived akin to a spirit or soul in the sphere outside of ordinary physical matter. Without matter there is no mind in the manner associated with a living person. The interaction between mind and matter, psyche and soma, is physiologically reversible—one affects the other. This unity does not stand alone, independent of extraneous essentials such as oxygen, nitrogen, and other vital elements and forces.

In the light of recent trends in departmentalization it could be conceived that the psychologist pays attention to the normal mental processes, the psychiatrist concerns himself with the abnormalities, and the physician confines himself to the physical state of the individual. The combined wisdom of the team is ideal. Their combined efforts are, however, not practical or necessary in everyday events. It is fundamental to the psychologist and to the psychiatrist to make certain first of the physical condition of the individual. For this reason the physician is the first port of call and the clearing-house. It should never be otherwise.

Habitually and traditionally, the physician has been visited for countless human ailments. The physician shoulders the great responsibility of the need to understand the individual properly, and to recognize his affliction. He must be sufficiently aware at all times of the attributes of troubles arising at both sources. Disabilities may have several facets. The origin may be purely psychological—namely, jealousies cause havoc; psychopathological—fright will precipitate hyperthyroidism in the predisposed person; pathological psychopathy—syphilis will cause dementia. Unadulterated disease without accompanying mental stress and emotional upsets is practially inhuman. All of this might be paraphrased by saying, "A sick person is never himself."

The term psychosomatic medicine is fast becoming a household phrase. It is a misleading term and, in reality, it is a misnomer. By comparison one hears of industrial medicine, aviation medicine, etc. All of these have some just claim because they cover specific problems. Psychosomatic medicine has no comparable distinction. It is in reality a basic principle of the whole of medicine to treat a person for his ailment. Attention may be directed

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more towards one or another aspect, but not without regard for the composite clinical picture. In that sense psychosomatic medicine as a separate branch of practice does not exist. In critical problems experts are of assistance the same as specialists in other fields.

Major Disturbances

There is a group of "functional disorders" which characterizes special types of human frailties. The defect is lodged in the autonomic or involuntary nervous system, which results in disharmonies of function. Some people turn white with fright, sweat with threat, parch with fear, pant with grief, vomit with revolt, and cramp without adequate cause. These do so because they are so constituted. The degree of provocation fails to induce the same response in most people. Some minor manifestations are only nuisances, such as fainting with a simple hurt. Other symptoms are due to more menacing disorders—vasospastic disturbances in the extremities, neurocirculatory disturbances, and irritable colons. There is no voluntary control over these commotions. None of these is promoted directly by the will or mind. Affect or feeling is naturally disturbed, but that is an attribute and not an essence of mind. Pacifying the mind is comforting and it reduces the intensity of the physical suffering. It is soothing to the underlying disturbance but it does not rectify the inherent defect. Patients in this group live long if not too well. They are made to feel much worse when they are wrongly informed they have bad hearts or diseased colons, etc. The symptoms are the result of purely functional disease without organic cause or pathology.

The second group includes countless people who are by nature peculiar personalities. These instabilities form the "psychoneuroses" and the persons are called, in short, neurotics. They are marked by their peculiar traits. Some are too apprehensive, too introspective, too self-centred, too uneasy, too changeable, too assertive, etc. Some lack sufficient confidence, self-reliance, a sense of security or feeling of friendliness. The root of their singular misconducts is a weakness in properly adjusting themselves in the manner of the average person to demands in their orbit of social activities. Their symptoms are the outcries of the impact with challenges which they cannot meet. This makes them appear as misfits and to feel disturbed. Experiences prove that—

> A marked and prolonged fall in self-esteem may be as devastating to the functioning of the organism as a marked and prolonged reduction in the blood count.

A lesson well worth learning, for all of us, is to recognize that tensions and conflicts and irritations have ways of expressing themselves through "organ language." Symbolically, something which "we cannot take" may be represented by the symptom of dysphagia (difficulty in swallowing). Nausea can represent a situation which "one cannot stomach." Sighing may express a feeling of a "load on the chest." The utmost fatigue, which is one of the most prevalent complaints, will ensue upon emotional conflict consuming all spare energy. Well fortified personalities are subject to transient phases of similar misconducts to that of a psychoneurotic person under extraordinary circumstances of stress and strain. In people of fortitude the effects produced last only for the duration of the stress. It is difficult for most people to conceive that such symptoms are human reactions to situations, not due to disease. Conviction may come through simple persuasion, and sometimes only by probing deeply into the life history of the chronic sufferer from cradle to wheel-chair. From this class spring the more serious anti-social misdemeanors—the delinquents, the drug addicts, the alcoholics, criminals, and larcenists.

A third more advanced group comes under the heading of the "neuroses." The patients "have only part of their personalities disturbed with a good

preservation of their contact with the world and minor degrees of distortion of reality." Their reaction to fear is abnormal. Their motivations are abnormal. They yield to compulsions and urges abnormally.

This group shows both mental and physical signs. The physical signs imitate organic disease as a by-product of the overpowering abnormal tendencies mentioned. Hysterical paralysis and traumatic neuroses are specimens. The anxiety neuroses—hypochondrias, neurasthenias, obsessions, compulsions, and phobias—are in the same category. It is hard to believe that human beings are subject to such perversions of psychogenic origin, in spite of themselves. It is harder still to bring conviction of this abstruse cause of their troubles to the afflicted and his relatives. Their misfortune is accentuated by the fact that they are too often victims of innumerable physical and surgical corrective measures long before the true nature of the underlying disorder is realized. Many of the neuroses are amenable to treatment by suitable modern techniques.

In the fourth group we meet with much more profound mental distortions, usually without physical symptoms. These severe disturbances come under the heading of the "psychoses." Patients in this class do not go voluntarily but are brought to see a doctor. The group includes manic depressive psychosis, schizophrenia, and paranoia. We must confess complete ignorance of the nature of the cause of the strange mental aberrations. Their course may lead to true insanity, which is a legal term more than a medical designation. The psychoses stand correction if they are benefitted by present-day shock therapy or surgical treatment.

Lastly, there is a double-header group: those who were deprived of mind at birth and those who were parted from it through physical causes such as injury or disease—the amentias. The lack of development ranges all the way from the dull-minded to complete absence of the intellect. The clinical types in the order of increasing amentia are: dull normals, morons, imbeciles, and idiots. Those who have become demented are victims of deteriorations following the psychoses mentioned, or by structural brain damage caused by disease or injury. The diagnosis is not difficult in both grades except in the early stages. Early detection is imperative for proper guidance. Society is obligated to mass action in that respect. Many can be made to fit into the pattern of life in a useful form. Those who cannot be made to fit, or who, by their presence, constitute a threat to peace and safety, require institutional confinement.

Concerning the Problem

It is erroneous to think that attention to the individual as well as his perplexity is a recent development in medical thinking. Physicians of long ago worked mainly on the strength of their knowledge of human nature. They explored and utilized the human approach more because they knew less of pathology. This understanding developed as an art, which is still a traditional part of medicine. In this period of transition towards the direct attack upon disease (introducing and employing scientific methods), personal attention was considerably neglected in the process and gain in other directions. The reawakening of the lost art has brought in its wake a revivalist fervor to make good the negligence. We are not witnessing a new discovery. We are seeing the correction of a partial omission. The endeavor now is to crystallize the subject by rationally interpreting suffering and treating it specifically. This is to replace blindly exploiting the intangible human touch, which unwittingly courts magic, quackery, and self-deception. The new turn is to exercise the art of medicine scientifically, by proved analytical methods, applied with reason on the basis of a better understanding of mental and physical suffering. This is good medicine—figuratively and literally.

Judging by the ascendancy of the psychiatric interest in patients at

present, and by the strong popular appeal, one might falsely conceive that there is an epidemic of insanity. Uncertainty in the lives of people in recent generations will best describe this period. Insane mass movements, which are still rocking the world, will probably characterize the times of today in history. *The percentage of insanity is not greater in the population.* There are more people in mental institutions because there are more institutions and there is more encouragement to receive shelter. The recent laudable drive towards social consciousness breeds also self-consciousness and personal anxiety. Uneasiness is acutely reflected in people by the rapid-fire freedoms and extended horizons. Breaks with established routines, customs, and habits cause dislocations in people and society. The upheaval brings good riddance to old taboos, senseless inhibitions, useless repressions, and misguided pruderies, but also the disturbed equilibrium originates new conflicts producing other frustrations. Parents are not as sure as they were by former standards of how to handle their children. Children are not so sure of their own limits. The old and the young are temporarily in doubt. When the wrestle and the tussle is with one's self, and the ego takes punishment, a doctor is called.

Directives

A new grip on a way of life would be more profitable than the present vogue—the new look. Mass education in the art of living will be a powerful force in stabilization. Continually reminding people to watch for symptoms of disease brings untold unhappiness. Only simple warnings are sufficient. It can be summed up by advising if you don't feel well, if something does not look right, or if you experience any sort of anguish, take time off to see about it. Go early and not late. Let your feelings and your reason be your guide. That more people see doctors more often than before is to be encouraged and, of course, we should be prepared to meet the obligation, and not forget simple rules of life. Sometimes one's clergyman or mother can accomplish more than cold science. Good advice is just as good medicine as any other standard remedy.

Society must direct its efforts to foster the art of living. Healthy people can thrive only on the provisions of freedom from want and freedom from fear. Otherwise it makes fertile soil for evil minds and weak bodies to grow. Heredity alone is a lesser cause. Education and reasonableness, not force or law, can regulate the mating of diabetics, hypertensives, epileptics, and others, with a view to lessening the incidence in future generations.

The medical and nursing professions must direct their energies towards positive health. Health has always been taken for granted and no instruction given in the methods of preserving it. We must show people how to keep well, not just how to recover from sickness. That will ultimately be medicine's greatest contribution to human betterment. That is the new outlook. In the accomplishment of these programs, teamwork is necessary. The doctor alone cannot take all the credit for the benefits to health generally and for the eradication of disease. The nurse, the engineer, the economist, the social worker, and other agencies all share.

To accelerate the program we must strengthen some weak links in the chain of the doctor-patient relationship in order to progress. I believe dependence upon the physician is greater than ever before. Confidence follows along more logical lines. Blind faith no longer attracts civilized people. We, therefore, should not treat to pamper but to improve and cure, with reason and realism. Explanations should be forthright and not camouflaged. We should teach and preach as well as heal. All the known factors at work besides bacteria as causes of ill-health should be equally stressed. It should be told emphatically that mental and emotional disturbances are a legitimate disability source. The stigma should be removed, not as an inducement for more of this

form of illness but rather that treatment may be directed to the proper cause. Imagination is our top rate distinction from the rest of the animal kingdom. It is a compliment, not an insult, to inquire into that faculty. Inherent constitutional inferiorities are not signs of sicknesses which can be overcome by drug store prescriptions. Age courts infirmities and nature demands concessions in the form of limitations; the signs should not be mistaken for disease because wrinkles and firm arteries are natural increments in the course of life.

It is surprising to realize how much suffering results from mistaken interpretations of doctors' opinions. It is a classifical phenomenon, now dignified in medical literature by name—"iotregenic disease." Differences of opinion should not shake faith when honesty and good judgment prevail. If complete uniformity is established and genuine differences of opinions no longer exist, it is a sign of stagnation.

CONCLUSION

I conclude by reminding you, firstly, that viewpoints in the nature of disease have swung from the mystic to the structural, and now to the functional concepts. Always in the past the particular viewpoint in vogue tended to carry too far. We must be on guard that the mark will not again be overshot. That psychological disturbances precede all cellular impairments is fictitious. Evil thoughts and bad feelings are not necessarily forerunners of the very many diseases.

Secondly and lastly, I fear we have become too gloomy and pessimistic. Alarm governs the lives of too many, too much. Many tend to fear the worst when they might instead hope for the best. That is strange in view of the unprecedented weapons at our command to combat as never before so many of the lethal diseases of mankind. We can live long with pathology and die of misery. In the face of the unknown, hope is a sensible refuge. I remember a quotation, "Science is bankrupt at the edge of the grave." Abandonment precludes all expectations: in hope there can be prospects even in adversity.

Rheumatism Facts

Rheumatic disease ranks second only to mental illness as a cause of human incapacity.

If all cases of rheumatic disease were diagnosed in their early stages and promptly submitted to the treatments which present medical skill can suggest, there would be a prompt and great reduction in the number of lives wrecked by its ravages.

As a result of rheumatic diseases, Canadian workers in 1947 lost an estimated 9.5 million days' work and 54 million dollars in wages.

An estimated 100,000 Canadians are totally or partially disabled by these diseases, possibly 15,000-20,000 being regularly confined to bed or wheel-chair. Another half million Canadians are disabled in varying degrees.

About 100 different kinds of arthritis have been identified. Articular rheumatism and arthritis are synonymous.

Generally speaking, the non-articular forms of rheumatism are the more prevalent. Although painful, they are less serious for they rarely lead to deformity, serious incapacity, or invalidity.

Cortisone, the new drug, is a hormone produced in the outer layers of the adrenal gland. It appears to have the power to reverse completely all symptoms of rheumatoid arthritis. It cannot restore function to joints already destroyed.

Owing to the complexity of and differences between the various rheumatic diseases, there is and can be no such thing as a single overall arthritis cure.

—*Canadian Arthritis and Rheumatism Society*

M.L.I.C. Nursing Service

Antoinette Richard (Hôpital St. François d'Assise, Quebec City) is taking the public health nursing course at the University of Montreal School of Nursing, having been granted a scholarship by the Metropolitan Life Insurance Co. *Marguerite Legault* (Sacred Heart Hospital, Cartierville, Que.) has been appointed to the Montreal staff.

Institutional Nursing

Psychiatric Nursing— A Specialty or an Essential?

GERTRUDE HUTCHISON

Average reading time — 6 min. 48 sec.

IT IS NOT MY INTENTION to answer the question suggested by the title of this narrative. Nor is it my intention to present it merely as a question. This is a problem—our problem.

Being democratic individuals we do not like others to answer our questions, or solve our problems, and indoctrination we abhor. Rather, we like to solve our own problems and answer our own questions in the light of our own knowledge and experience. Also, being democratic, we are just, honest, and eager for knowledge that will make the good life more worth living.

For that reason we are going to consider seriously a series of questions, bring up a few pertinent facts, and philosophize some. We may wonder what bearing such apparently irrelevant material can have on the topic, but perhaps if we find answers for the questions here set forth we have also answered the topic.

Have we become weary of the awful statistics that compel us to face reality? But, have we faced reality? Or, have we just tired of hearing? Have we become negatively adapted to statistics and failed to grasp their real significance? Have we genuinely thought of the problems these statistics present, delved into them, or exerted any real effort to solve them?

There are more patients in mental hospitals than in all other hospitals combined. If mental illness increases in the future at the rate it has in the past, the time is not far distant when we shall have more patients within than without mental hospitals. The significance of this statement is appalling. If or when the majority of us are living inside mental hospitals, who is going to care for us? Who is going to carry on a program of prevention for those of us still on the outside? Or, will we have time then to consider mental illness in the light of the true facts? Our modern civilization is not becoming any the less complicated.

It has been estimated that of all the patients in general hospitals, at least 35 per cent require psychiatric care. This does not include the emotionally confused and unhappy individuals in our communities.

We are told that 75 per cent of those who want psychiatric help cannot receive it for lack of facilities. Do we know the average number of nurses employed in our mental hospitals? Who is taking the responsibility of the welfare and care of our mentally ill? How many people need help but don't understand or realize the nature of the help they need? How many of us, as nurses, are prepared to help these people and take an active part in the prevention of mental illness? The facts now begin to over-

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whelm us and, indeed, threaten to paralyze us by their magnitude.

But, these are not just statistics! These are *us!* The figures tell the story of families, our neighbors, our communities, little people, big people, people in trouble—*Us!*

What is the nucleus of our universe? Is it people who think and feel and have problems that they cannot understand because they cannot understand themselves? What do we know about ourselves—our mental, emotional, and social aspects? Are we developing and learning all branches of science yet ignoring *us*—neglecting the science of the individual? Does our school curriculum offer social sciences in a ratio that is comparable to our other sciences? Are we providing our student nurses with facilities for application of the principles learned from our social sciences?

What is the nucleus of nursing? Is it the patient, the individual? What is an individual? Is it a mind, a body, an emotional force, or is it a unique and integrated whole? Can we care for one aspect of an individual and ignore another? Do we know the individual, our patient, well enough to determine in which aspect his need lies? How can we learn these things?

Is nursing education geared to the service of the public and guided by their needs? What are the needs of the public? These are a few questions, asked for millions; a few statistics compiled from among us; neither of them can do justice to the impact of our pleas.

The nurses of Canada are a vital part and a potential asset in the solution of these problems. What can we do? Where can we begin? With psychiatric nursing? Can the principles of psychiatric nursing be applied to all nursing with benefit to the patient? Psychiatric nursing is nursing in any situation where the behavior of the patient, not just his overt acts but also his thinking and feeling, is of paramount importance.

Of what significance is behavior? What does behavior tell us about the individual? Do we know which behavior is appropriate or inappropriate in a given situation? What can we do to modify it?

A behavior problem represents a need. It may be a need for attention, to dominate the situation, for security in self, but whatever the need responsible for the behavior, treating the symptom, which is synonymous with modifying behavior, is without value unless the underlying cause is understood and treated also.

Do we find behavior problems in general hospitals? Do we find them in our communities—people who are "difficult," "unco-operative," "demanding," "querulous," unwilling to do what we, the nurses, think they should do at a given time? Do we recognize the anxiety, depression, and inappropriate emotional reactions behind the behavior? Can we interpret this behavior and do we know the "nurse-patient" relationship in each situation?

An excerpt from an article written by Olga Weiss in the *American Journal of Nursing* may throw some light on our problem:

> She, the psychiatric nurse, must learn to respect her patients as fellow human beings. The person who develops a wholesome respect for other persons as individuals, with the same rights and privileges as himself, has taken great strides toward reaching understanding.
>
> This is perhaps the most difficult lesson for the nurse to learn, as it means giving up some of the privileges of being a nurse—an authoritative creature in a white uniform whose word is law. Because nurses are trained so rigidly, they tend to become rigid, and it is not easy for them to give up some of the precepts learned so painfully. It is difficult to substitute skilful conversation for manual dexterity; the former actually demands more of the nurse. The psychiatric nurse must learn to give much of herself to the patient—her time, patience, and understanding. By understanding we do not mean the useless, sweet, blanket understanding of the willing, the trained volunteer who pats the hand of a withdrawn schizophrenic and speaks condescendingly to him. The nurse working with such patients must

> have a truly scientific knowledge of the illness and its symptoms, and must recognize that these people, no matter how withdrawn they may seem, are acutely aware of what goes on around them and that condescension is as infuriating to them as to any well person.

Is it not obvious that the nurse everywhere must have the same skill, the same warm understanding, the same ability to give of herself to the patient? Does our nursing education provide for the acquisition of these skills and abilities?

In the community where public health nurses are at work, can they cope with the many who are "blindly groping in that dreaded No Man's Land between reality and unreality, sanity and insanity, sick, cross, cruel, queer, prejudiced or incompetent"? Are the atrocities of which we read every day merely manifestations of inner conflict and mental illness?

Every community holds those who are sorrowful, disillusioned, dissatisfied; those whose lives are rounds of boredom, devoid of any real interest or ambition; those who carry about a sense of failure or futility; those who are haunted by a sense of guilt or a feeling of inadequacy; those not classified as mentally ill, but whose lives are dominated by worry, anxiety, hatred, or fear. There is every indication that this group will increase.

In the field of social service, the need for a knowledge of psychiatry and its principles has been felt to such a degree that it has become an integral part of the course. In education, its principles are being incorporated into methods of teaching. Indeed, its principles are changing the very objectives of education. In the field of crime and delinquency, an awareness of the need for psychiatry is being acknowledged and applied in treatment and prevention.

And what of nursing education? Have we realized a felt need? What are we doing about it? Are we exerting ourselves to our greatest potentialities or are we shelving our responsibilities because of the tremendous adjustment and inconveniences presented? Have we realized our responsibility to the public and our student nurses? Do we believe in attending to "first things first," "rectifying obvious inequities," or do we tend to sit back with a full realization of these implications and wait for a more aggressive or progressive group to show us the way?

Do we want the emotional lives of our patients to become the responsibility of social service workers and psychiatric nurses alone? Do we want to assume responsibility for the physical aspects of the patient alone? Can we separate the physical aspect of the individual from the whole and give it intelligent nursing care? Are we preparing ourselves to care for the greatest needs of our people?

It is the concern of all serious-minded people and to the nursing profession at large it presents a major challenge. "Is psychiatric nursing a specialty or an essential of nursing education?"

Bringing Up Children

> Each person has his or her own ideas about how young children should be brought up—ideas which generally correspond to the sort of person he himself is or, put another way, to the way he was treated by his parents. Oftentimes, therefore, parents unconsciously act out in their responses to the child their own needs and their own feelings, without recognizing or giving what the child needs most. The aim of parents must be to attain some measure of self-understanding and awareness of their needs, thereby freeing themselves to give more fully of this feeling of security which their children require.
>
> THOMAS *and* DAVIDSON *in* "Social Problems of the Epileptic Patient"

The nurses of Prince Edward Island have passed a resolution to include their subscriptions to *The Canadian Nurse* with their annual fees.

Psychiatric Care Challenges Nursing

ELSIE C. OGILVIE

Average reading time — 7 min. 12 sec.

DR. MARY SHERFEY wrote in her article, "Psychiatry Belongs at the Bedside," in the *American Journal of Nursing*, October, 1947:

> There has been a growing realization that psychiatric training is not only valuable but absolutely necessary in any branch of medicine . . . the increased interest in psychiatry in the medical and nursing schools, the various social institutions, the movies, the stage, literature, and in general, represents a trend in social thinking.

Aside from these broader interpretations in relation to public thinking, we are aware of the fact that there has been considerable change in the attitude of the public towards mental illness—their acceptance of the fact that a person is just as liable to have a mental illness as a physical illness. It still is difficult, of course, for the individual who has had a mental illness to find total acceptance in the community, especially in re-establishing himself in a job. This latter problem has increased with the advances in therapy and larger proportion of patients who are discharged from mental hospitals today.

Paralleling the strides in the treatment of psychiatric disorders, more investigation is now being made into the causes and underlying factors in the various types of mental illness. Much greater stress is being put on the preventive angle. Recognition of the need for preventive work is evident in many phases of community life. The nursery school, for instance, provides opportunity for study and research in normal behavior of children. More emphasis is being placed on the adjustment of the child in the home and the school. The opening sentence of an editorial in the Charlottetown *Guardian*, titled "Mental Health in Schools," stresses this point: "The mental health of the school child has a definite effect upon his physical health." With respect to the mental health of school children the Committee for School Health Research has recommended that:

1. Teachers in service receive instruction in child psychology and in the detection, appreciation, and solution of types of mental health problems.
2. Gifted children receive definite consideration in the larger schools in each province and that enriched programs be the minimum provision for such children in all schools.
3. Suitable provision be made for backward pupils in elementary schools.
4. Suitable provision be made for physically handicapped pupils in elementary schools.
5. In secondary schools a varied program be provided for students of different interests and capacities and diagnostic services be provided for maladjusted students.
6. Guidance programs in both elementary and secondary schools be extended to problems of social adjustment.
7. A study be made of the incidence and causes of poor mental health among teachers.

Some of the provinces are already making it possible for teachers to gain an insight into mental health problems.

The establishment of child guidance clinics is widespread but many areas are still without this service. The family court gives recognition to the value of psychiatric consultation. The development of more mental health clinics is a prospect for the future.

The professional fields are turning their attention to the preparation of more individuals to meet the growing needs of this extending program of prevention. Medical schools are introducing more intensive courses

Miss Ogilvie is lecturer in supervision in psychiatric nursing with the McGill University School for Graduate Nurses.

for their students as well as establishing means for graduate study; clinical psychologists and psychiatric social workers are being prepared. *What is nursing doing to meet this challenge?* Three developments are possible at the present time:

1. Providing psychiatric affiliations for all undergraduate students.
2. Making use of our clinical facilities in establishing courses where groups of nurses can obtain at least some preparation in the field.
3. Encouraging every nurse to avail herself of the opportunities provided.

It is essential that all of the profession work together in forwarding these projects in order that as large a number of nurses as possible will be able to meet the challenge. The following statistical data of the existing situation give a vivid presentation of the need for a careful study of the problem:

> In Canada in 1945, there were 169 schools of nursing with an enrolment of 12,151 students and 11 university schools with an enrolment of 682. By 1947, 11 schools of nursing were being conducted in mental hospitals (enrolment 242) with 7 mental hospitals conducting an affiliation course for student nurses. Only 43 general hospitals and 2 university schools were sending approximately 116 students for affiliation every 3 months—an average of 464 students each year.

This is, indeed, a small number of students to receive experience in psychiatric nursing.

As of December 31, 1945, the number of registered graduate nurses in Canada was 33,338. The Dominion Bureau of Statistics report for 1945 showed that 886 nurses were on the staffs of the mental hospitals. By 1947 this number had decreased to about 500. At the same time, the approximate number of patients in the mental hospitals was 50,000—almost as many as there are in all other types of hospital combined. These figures emphasize the relatively small number of nurses who have been valiantly carrying the herculean task of providing the nursing care for this large group of patients.

In all branches of medicine the nurse is well versed in her various duties. In the course of three years, the rotation of her training affords her experience in each of the specialties. Unfortunately, this does not include psychiatry for many of them. Yet, this is the branch of medicine which best gives the nurse the knowledge and ability to understand the total patient. Paracelsus, a 16th century medical sage, wrote, "He who wants to know man must look upon him as a whole and not a patched-up piece of work. If he finds a part of the human body diseased he must look for the causes which produce the disease and not merely treat the external effects." In the preparation of nurses in the future we should see that they are more fully qualified to carry out the art of nursing in its truest sense.

What are the problems that hinder the establishment of an affiliation for every student? Certainly it is not a lack of clinical facilities. Why have so few nurses chosen this field? We hear that it is due to the type of nursing and the type of patients who have to be cared for; that nurses are fearful and various other reasons. Perhaps the fault lies in the way in which psychiatry has been interpreted to the student nurses. How many instructors in general hospitals have had experience in this field and know what they are talking about in the instructions they give?

Where the students are actually getting psychiatric experience, is there any correlation with the rest of their course or does their interest die as soon as their experience ends? Naturally the student will benefit from such affiliation and so will her patients, but for it to be really effective there should be a broader interpretation of its relation to other services in the hospital and community.

Should all graduate nurses have psychiatric experience? I would say definitely all, and especially those going into the public health field, Victorian Order, and industrial nursing. If we are to be prepared to participate in the program of preventive

work these are our key people. How can we best utilize the facilities at hand, in order that as many as possible can gain some experience in this field? If advanced preparation is not available can we provide for some intensive lecture course and field experience?

Some of the provinces have a planned program whereby public health nurses are able to have an intensive course of three to four weeks in a clinical situation. This is a beginning. It should be developed to a greater extent so that all who are in this field now, and are or will be in supervisory positions, will be equipped at least to the level of the members of the staff who have had psychiatric affiliation.

The McGill School for Graduate Nurses started a one-year course in supervision in psychiatric nursing in 1945-46. The University of Toronto School of Nursing offers a one-year course in this same field. General post-graduate courses for graduate nurses are available in the following mental hospitals:

Provincial Hospital, Brandon, Man., 6-mo. course; Provincial Hospital, Ponoka, Alta., 8-mo. course; Provincial Hospital, Essondale, B.C., 6-mo. course.

The preparation of these well qualified specialists is the first step in meeting the challenge this whole field of care and prevention presents. Let us not be dilatory in developing our share of this important program.

In Memoriam

Martha Campbell died in New Westminster at the age of 85. Miss Campbell had engaged in nursing for 37 years.

* * *

Bertha Cunliffe, who was supervisor of nurses' residences at the Vancouver General Hospital from 1923 to 1946, died in Vancouver in June, 1949.

* * *

Maude E. Gallaher, who graduated from St. Luke's General Hospital, Ottawa, died recently in Montreal. Miss Gallaher served overseas during World War I.

* * *

Molly Hardy, a graduate in 1927 from St. Joseph's Hospital, Victoria, died recently in Seattle. Miss Hardy served with the Imperial Army during World War II.

* * *

May (Fairhurst) Hegsterom, who graduated in 1925 from St. Joseph's Hospital, Victoria, died recently in Dawson, Y.T., at the age of 47.

* * *

Kathleeen McDonald, a graduate of the Children's Hospital, Winnipeg, died in Winnipeg on September 16, 1949.

* * *

Margaret Ann Scott, who graduated from the Glace Bay General Hospital, N.S., in 1929, died suddenly in Boston early in September, 1949. Miss Scott had worked in the United States ever since graduation.

* * *

Marjorie Anna Rae Stewart, a popular student at the Ottawa Civic Hospital, died on September 11, 1949, at the age of 22, following a prolonged illness.

* * *

Gladys Ethel Strum, who graduated from the Royal Victoria Hospital, Montreal, in 1919, died in Halifax on October 2, 1949, at the age of 62. Miss Strum had served as superintendent of nurses at the Victoria General Hospital, Halifax, for 24 years. She retired in 1945.

* * *

Meryl A. (Johnston) Wallis, who graduated from the Toronto General Hospital in 1942, was killed in a motor accident on September 15, 1949. Prior to her marriage, Mrs. Wallis had served as a nursing sister with the R.C.A.M.C.

A child born with impaired hearing is by no means entirely deaf. He may hear low tones well but miss the higher ones. Vowel sounds can be produced if he can hear low tones well and middle tones fairly well. If the higher tones are missing, he will be unable to produce consonant sounds.

Aux Infirmières Canadiennes-Françaises

Initiatives Désirables

BRIGITTE LALIBERTÉ

Lecture — 13 min. 36 sec.

APRÈS LA LONGUE kyrielle d'ennuis, de frustrations de toutes sortes, énoncés par celles qui m'ont précédée, on ne peut certes dire des infirmières que, comme les peuples heureux, elles n'ont point d'histoire. Non plus, ne pouvons-nous caresser l'idée qu'en adoptant tel ou tel système nous aurons enfin trouvé la formule magique qui remédiera à tous nos malaises, voire même à nos maux les plus cuisants. Si le développement progressif d'une association telle que la nôtre ouvre sans cesse de nouveaux horizons, nous réalisons, hélas, que ces nouveaux horizons laissent entrevoir de nouveaux problèmes. Il nous faut, cependant, nous rendre à l'évidence que si nous ne pouvons solutionner tous ces problèmes, nous pouvons, dans une certaine mesure, en prévenir un grand nombre et en atténuer d'autres, par une étude objective, dénuée d'émotivité.

Pour ce qui a trait à l'infirmière étudiante, Soeur Louise de Marillac et Mlle Desmarais vous ont parlé des avantages des tests dans les écoles d'infirmières. Afin de rendre service, je dirais, même justice à la profession, ces tests devraient être faits avant que l'élève soit admise à l'école d'infirmières. Si l'on calcule qu'une personne satisfaite ou mécontente influence au moins une dizaine de personnes, il est facile de calculer les répercussions lorsque l'on a gardé une jeune fille à l'école pendant quelques semaines, quelques mois et, quelquefois, au-delà d'un an.

Nous comprenons que, pour les petites écoles, les services d'un psychologue dûment qualifiée sont absolument inadmissibles. Rares même sont les grandes écoles qui pourraient supporter un tel fardeau. (Ici, je ne parle nullement de la présence d'une telle personne, mais bien des honoraires à payer.) Le même problème se posait, d'ailleurs, aux Etats-Unis et voici comment on l'a résolu. La National League of Nursing Education, convaincue que toute profession a une obligation envers la société qu'elle sert, en plus de l'obligation morale qu'elle a envers ses membres — c'est-à-dire, le maintien de hauts standards professionnels ainsi que d'une survivance assurée — a établi, en 1941, un service connu sous le nom de "The Pre-Nursing and Guidance Test Service." Lorsqu'une demande d'admission est faite dans une école, la directrice, l'assistante, ou la personne en charge des admissions, remet à l'aspirante, après l'entrevue, selon qu'elle le juge nécessaire, un prospectus ainsi que les formules nécessaires à remplir. On lui explique bien qu'elle puisse croire avoir les dispositions et le talent nécessaires, mais qu'elle ne sera admise qu'après avoir subi les épreuves des tests — i.e., tests d'intelligence, tests d'aptitudes, inventaire de personnalité, etc. De cette façon, la candidate ne commence pas à faire des dépenses et à avertir ses parents et amis qu'elle "rentre garde-malade." Que peut-il y avoir de plus humiliant pour une personne que d'être fêtée, recevoir des cadeaux ainsi que des félicitations, pour se retrouver au bout de quelques semaines, et bien chanceuse si ce n'est que quelques semaines, de retour à la maison et d'avoir à admettre qu'elle a été renvoyée, ou à inventer des

Mlle Laliberté est directrice du nursing, Service de Santé de la cité de Montréal.

excuses de maladie, ou tout simplement "qu'elle n'aimait pas cela." Ces excuses inventées, ou cette manière de traiter la candidate rejetée n'aide certes pas au recrutement. Sachant qu'elle doit subir des examens, elle se tiendra sur la réserve; même refusée, elle gardera toujours un bon souvenir de l'hôpital.

Environ deux ou trois fois par années des assises sont tenues dans les grands centres; les aspirantes jugées admissibles doivent se présenter pour subir les tests requis. Un membre de la National League, dûment qualifié, soumet la candidate à des tests qui sont bien préparés et bien standardisés. Souvent on a recours à l'aide de finissants des facultés de psychologie des universités avoisinantes. La National League défraie le coût de voyage et les honoraires du ou de la psychologue; l'aspirante défraie ses propres dépenses. Les listes sont corrigées par la National League et les résultats sont compilés et retournés à la directrice où l'aspirante a fait sa demande. Si elle a réussi, elle est invitée à entrer dans les rangs de la Légion Blanche. Si les résultats ne sont pas satisfaisants ou promettent peu de succès, la directrice lui fait comprendre qu'elle a peu de chance de réussir et qu'il vaut mieux, dans son intérêt personnel, de se diriger vers telle ou telle autre occupation. Il faut donc que la directrice ou la personne chargée d'une telle tâche possède un entraînement en orientation. Sans être un docteur en psychologie, il lui faut une certaine formation.

Ce genre de travail paie et paiera d'énormes dividendes par la suite à la personne concernée d'abord et, pour être plus égoïste, je pourrais dire à l'école premièrement, à la personne concernée, et puis à la profession tout entière.

J'ai mentionné plus haut que, lors de l'application, l'on devait remettre un prospectus. Que doit contenir ce prospectus? De belles images montrant de coquettes petites chambres, de belles salles de jeux ensoleillées, des salles de cours, des salles de malades, des bibliothèques, le tennis, la piscine, si vous en avez une, et d'autres attractions, en plus de l'énumération du nombre d'uniformes, souliers, etc., à se munir. Je vous concède que comme médium de publicité ceci est très désirable, mais il y a beaucoup plus. Ce prospectus doit contenir les réglements en détail — le nombre d'heures de cours par semaine, le nombre d'heures d'étude exigé, le nombre d'heures de pratique, le nombre d'heures de liberté, la période de vacances, la rémunération s'il y en a, les frais à encourir, les procédures à suivre en cas de maladie, de deuil, les mesures disciplinaires imposables, les causes de renvoi, etc. Rien ne doit être laissé au hasard; tout doit être très explicite.

L'aspirante, ainsi que sa famille, ont eu amplement le temps de se familiariser avec l'institution choisie: ça leur plaît ou ça leur déplaît. On a parlé des causes de départ chez les infirmières étudiantes: entre autres, la surprise des candidates lorsqu'elles réalisaient qu'elles n'avaient pas de longue fin de semaine. Si l'on avait eu un manuel dans ces écoles, ces jeunes filles auraient su qu'elles n'avaient pas leur fin de semaine, alors elles n'y seraient jamais entrées. Ne croyez-vous pas que ce procédé serait plus économique pour l'aspirante et pour l'école? Il y aurait économie de temps, d'argent, et d'émotion des deux côtés.

Si l'aspirante entre, munie de tous les renseignements, c'est qu'elle accepte et qu'elle est prête à faire les sacrifices nécessaires. Au point de vue psychologique, elle a déjà franchi une première étape importante: celle de s'adapter à son entourage. Dans les écoles d'infirmières progressives, un comité d'orientation est établi. Ce comité se compose de la directrice, de l'assistante, des institutrices, des hospitalières et des assistantes-hospitalières. Chaque élève est assignée à une conseillère.

Au cours de ses trois années d'études, l'élève a au moins une conférence par mois. Si l'élève a un problème qu'elle ne peut résoudre elle-même, elle peut aller en tout temps voir sa conseillère. Ces pro-

blèmes peuvent aller du sublime au ridicule: ennui, difficulté de s'entendre avec une compagne de chambre, certaines remarques d'un médecin, questions de scrupule, etc. Elle doit toujours être reçue avec sympathie et bonté. Un dossier cumulatif ou journal est tenu: la date, le problème, ce que l'élève propose comme solution, et la signature de la conseillère y sont enregistrés. A la fin du cours, avec ces données et le degré de maturité atteint, il sera possible d'orienter l'infirmière vers une branche du nursing où l'on a raison de croire qu'elle réussira le mieux.

Ce n'est pas tout, non plus, de la bien conseiller. Il faut qu'elle acquière de la compétence sociale et, pour ce, elle a besoin d'être aidée. C'est pourquoi nous trouvons dans plusieurs écoles, comme dans les universités, les grands collèges, et couvents, un comité exécutif d'étudiants avec plusieurs sous-comités. Les buts de ces comités et sous-comités sont d'abord de promouvoir un esprit de solidarité, de développer l'initiative de chacun; d'incalquer et de développer à son maximum le sens de la responsabilité.

On s'étonne de voir, dans certains milieux, des infirmières diplômées si peu conscientes de leurs responsabilités personnelles et professionnelles. Est-ce bien de leur faute? Ont-elles été aidées dans ce sens? Continuent-elles à être aidées? Tout ce que j'ai énoncé plus haut s'applique également à l'infirmière diplômée, employée soit dans un hôpital ou dans une organisation publique.

Tout être humain a besoin de se sentir important, de se sentir respecté et apprécié; tous, nous avons besoin de nous sentir dans un état de sécurité raisonnable. Afin d'en arriver là, l'hôpital qui emploie des infirmières diplômées, aussi bien que l'organisation d'un service d'hygiène, doit avoir une ligne d'autorité bien définie, avoir des procédures écrites, ainsi que des règlements écrits et en vigueur. Rien ne servirait d'avoir tout écrit s'il y a autant d'applications diverses qu'il y a de sautes d'humeur. Rien ne contribue plus à frustrer un individu que de recevoir des ordres et des contre-ordres, de marcher au petit bonheur sans savoir ce que le lendemain peut lui apporter.

En terminant, comme directives et initiatives désirables pour l'infirmière diplômée, je suggère d'ouvrir un bureau central de placement, bureau tenu par l'association même.

Je conviens avec vous que je vous ai présenté en peu de temps un sujet de la plus haute importance, sujet nécessitant une étude approfondie. Je suis sûre qu'il s'en trouve parmi vous qui diront: "C'est très beau tout cela, mais pas très pratique!" Mon professeur, le Dr. Ordway Tead, disait: "Dans la vie vous rencontrerez deux catégories de gens: ceux qui se disent pratiques et les idéalistes. Les gens pratiques," disait-il, "sont ceux qui persistent à répéter les mêmes erreurs. Les idéalistes sont ceux qui marchent vers un but en contrôlant et en modifiant constamment leurs méthodes pour atteindre ce but." Soyons des idéalistes, marchons toutes ensemble vers le même but: améliorer notre profession.

Qualifications for a Good Leader

He or she must have the curiosity of a cat, the tenacity of a bulldog, the friendship of a little bird, the diplomacy of a wayward husband, the patience of a self-sacrificing wife, the enthusiasm of a Sinatra fan, the good humor of a comedian, the assurance of a Harvard man, and the tireless energy of a bill collector.

—*M.L.I.C. Quarterly Bulletin*

How Children Die

Accidents account for more deaths in children than any single disease and statistics show that the majority of these accidents occur at home. Many of these mishaps are preventable. In many cases thoughtless careless parents pave the way to disaster by leaving in the open, matches, poisons, knives, and other dangerous articles. Children are naturally curious. It is the parents who must take care.

Public Health Nursing

Mental Health for All

RUTH MCCLURE

Average reading time — 7 min. 6 sec.

MENTAL HYGIENE is becoming a subject of vital interest to workers in the field of public health. It has long been recognized that physical and mental health are interdependent, yet preventive measures for maintaining sound mental health have not kept stride with those employed for the promotion of sound physical health. It is also true that this phase of public health has often been looked upon as a specialized branch or as part of psychiatry. If we clarify in our own minds the difference between psychiatry and mental hygiene we realize that the former deals with treatment and restoration of the mentally ill, whereas the latter is concerned with the prevention of mental illness. With the increasing number of admissions to mental hospitals, the prevalence of psychosomatic disorders and the high incidence of psychoneurosis, public health authorities are realizing the need for sound preventive, rather than curative, measures.

Two years ago a mental hygiene program was incorporated in the generalized public health activities of the Edmonton Rural Health Unit. The idea originated in the mind of the Medical Officer of Health, Dr. H. Siemens, who, with the co-operation of other interested workers in the province, formulated the plans for such an undertaking. Because of limited finances in beginning this program, it was decided to concentrate on the school-age group. This is a logical group to focus our attention on as it has been estimated that 20 per cent of the school population in Canada suffer from emotional disturbances of one form or another. The correction of maladjustment in this group is, of course, very necessary, but more important is the prevention of emotional disturbances in the remaining 80 per cent. The business of child training, guidance, and education is of prime importance if we are to have happier emotional lives for children, and personally happy and socially useful adults.

A supervisor of mental hygiene, who had received the necessary training in a child guidance training centre, was added to the health unit staff to devote his full time to this work. During the term, he visits each classroom in the district to acquaint the teachers with the mental hygiene service. A careful survey is made of the schools to find children with emotional disturbances. In many cases, the problem can be corrected by a thorough discussion of the case and by giving the teacher a better understanding of the problem and guidance in dealing with it. Serious cases of maladjustment are referred to the Provincial Guidance Clinic where both child and parent are interviewed by a psychiatrist. Recommendations and findings are relayed to the teacher by Mr. MacDougall, the supervisor. At follow-up visits to the school, he is able to note progress that has been made or give any further advice and assistance to the teacher.

Health education is one of the most important functions of any health

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Practical experience in planning the in-service training program for new members of the nursing staff of the Alberta Department of Public Health gave Miss McClure her background information for this article.

unit. Likewise, the basis for sound preventive mental hygiene service lies in education. In co-operation with the Department of Health and the Faculty of Education, a course in constructive medicine has been held during the month of July for the past two years. Twenty-two teachers in the health unit area have now taken this course which is designed to train them for more effective assistance in the mental hygiene program and in all functions of the health unit. Members of the health unit staff were also given the opportunity of taking the course. Adult study groups are conducted by these teachers in their local school districts. Books and pamphlets on a variety of health subjects may be borrowed by any resident of the district from the health unit library. In communities where such study groups were conducted last year, there was an increased interest shown in the work of the health unit and more efficient use was made of the available services. The process of education is slow and gradual but by continued efforts, such as this, it is hoped that better mental and physical health for the individual and the community will result.

You may ask, "What is the rôle of the public health nurse in such a program?" She must not consider mental hygiene as a separate service but must incorporate it into all aspects of her work. This means a reorientation of the nurse's attitude toward public health. School examinations or inspections provide an opportunity to observe the mental as well as the physical health of the child. It is important to note such defects as decayed teeth, enlarged tonsils, or impaired vision and try to have these corrected. It is equally important to be aware of abnormal behavior or emotional disturbance. Nail-biting, undue shyness, over-anxiety, fear, and enuresis are usual symptoms of mental unrest.

In her work in the community, the nurse attempts to interpret public health to the family and its members. In order to do this, she must have an understanding of *people*—how they live, act, and think. She has a natural entry into the home and has an opportunity of seeing them in their normal environment. She observes signs of physical illness, gives advice on infant care, immunization, nutrition, and various other subjects of health. Because of her close contact with the family, the nurse has the added advantage of being able to establish the rapport which is so essential in assisting those who show signs of emotional strain and tension.

Too often we are concerned with the physical development of the individual and pay no attention to his social or emotional development. Home visits are often hurried. We are too intent on getting our teaching across to take time to listen and observe. We are prone to measure the success of our work in terms of statistics—quantity rather than quality of the work may then become important. A successful home or school visit is not a hurried call—it is very time-consuming. Always it is important to remember that we are dealing with individuals. Care of the individual and not the case is the core of the nursing activity.

The nurse is not expected to be a mental hygienist nor a psychiatrist. However, a great deal may be done through staff education and conferences to help her gain a more thorough understanding of human needs, of child development and habit patterns so that she will know what is normal behavior and recognize deviations. She should also have an understanding of the factors which contribute to mental unrest and emotional strain and know where to refer an individual for proper advice and treatment.

One of the greatest advantages to be gained from a mental health program is the effect of it on the staff itself. It is impossible to help others to better mental health without recognizing and correcting problems which exist in our own emotional make-up. This leads to more congenial relationship, co-operative efforts, and sympathetic understanding of other members of the staff—all leading to a more effective program of public health.

Trends in Nursing

Average reading time — 5 min. 36 sec.

Supervisory Training

Hospital administrators from 14 states met recently at Cornell University for a workshop on "Supervisory Training in Human Relations." The conference was conducted by the New York State School of Industrial and Labor Relations, in co-operation with the American Hospital Association.—The *Modern Hospital*, Sept. 1949.

Pre-Clinical Education in Hospital

"The modern hospital must relinquish the control of nursing education to institutions whose primary purpose is education"—so say Bixler and Bixler in an article on nursing education published in *The Modern Hospital*, September, 1949. They continue to note that while college is not a playground for the average young student, it presents a sharp contrast to the concentrated pre-clinical experience of hospital students. Nursing students are plunged into a dizzy round of classes and laboratory periods, with "subject matter consisting of arrays of scientific terms and processes, which they are expected to learn by memoriter procedures because there is not time to learn by assimilation . . . No one has ever justified this cramming process in the pre-clinical period in traditional schools of nursing. As a favorable learning experience, it is indefensible."

Approximately one-third of the students do not survive the pre-clinical period. Might this be due to the fact that these young women are rushed through the program for purposes which are not educational rather than to the lofty intellectual level of the program? "They are required to learn too much, too superficially, in too short a time in a situation that is too complex and too strenuous for a proper learning atmosphere." The suggestion is made that this step of the transfer of control of nursing education to institutions of higher education need not divorce the student entirely from the hospital. Hospital administrators and trustees rather should recognize the hospital's role as a co-operator with higher education in furnishing clinical facilities and supervision of clinical experience for nursing students.

New Methods in Hospital Service

Cleveland's Clinic, in the process of expanding their program with a graduate nurse staff hardly one-third that of normal times, achieved optimum efficiency in patient care by the installation of a hostess and housekeeper system designed to relieve nurses of many routine duties.

Room service was made entirely responsible for setting up the patients' unit. The housekeeper received, each morning, a list prepared by the hostesses of the patients going home. The hostesses assumed responsibility for checking in each patient, for handling telephone calls and messages, and for obtaining receipts for flowers or other deliveries. The hostesses also contacted relatives, assisted with financial arrangements, and facilitated clearance of bed or room units. Permanent hostesses in the hospital now number 20.—*The Modern Hospital*, Sept. 1949.

Internships for Housekeepers

With a view to conserving nurses' time, the Overlook Hospital, Summit, N.J., is setting a pattern for housekeeper internships. Frances Penfield, in a paper presented at the clinical congress of the American College of Surgeons, described the program at Overlook. The training is of six months' duration from 8:00 a.m. to 4:00 p.m., six days per week. About

three hours daily are spent in lecture and the remainder of the time is devoted to learning "on the floor."

> The interns will be given a complete background in all phases of hospital housekeeping, including management of personnel, job analysis, time studies, departmental relationships, and supplies.
> —*The Modern Hospital*, Sept. 1949.

Have You Tried It?

The two-way call system might save some of those fatiguing corridor trips, conserve time, and provide more efficient service to the patient. Read the report from St. Barnabas Hospital, Newark, N.J., to be found in the September number of *The Modern Hospital*.

Has Canada A Similar Problem?

Important reading for every person, especially those connected with the nursing profession, are the shocking facts about the frauds who endanger public health which are disclosed in the article "Is She *Really* a Nurse?" in October *Good Housekeeping*.

According to Dr. Esther Lucile Brown of the Russell Sage Foundation, who made a definitive study of the nursing profession, "anyone may put on a uniform and simply call herself a 'nurse'."

The article cites the fact that the 280,000 registered nurses, with three or four years of specialized training, who are practising in the country today are outnumbered by "some 300,000 other women who call themselves nurses, or sometimes practical nurses, but who lack the most elementary knowledge of their profession."

Contrasted with the three states—New York, Arkansas, and Louisiana—which have recently passed laws forbidding any unlicensed person to nurse for hire, there are 45 remaining states which "still allow any unlicensed, untrained person to call herself a nurse and get paid for it."

The article exposes the more than 300 so-called "quickie commercial and correspondence schools," some of which claim to teach, in 53 lessons by mail, the entire range of nursing skills for $75. These schools, one of which turns out over 200 "graduates" each month, are compared with the Civil Service training requirement for a practical nurse—400 hours of instruction and 1,200 hours of supervised nursing care. One of the commercial schools registers a student in the morning and sends her out as a "nurse" the same evening.

As a means of combatting this real danger to public health, the article recommends that all states pass laws, forbidding anyone to nurse for hire who has not met prescribed standards and passed prescribed tests.

The American Nurses' Association has described the article as "an outstanding public service."

Orientation et Tendances en Nursing

COURS PRÉLIMINAIRE DANS NOS ECOLES

"L'hôpital moderne doit abandonner la direction des études d'infirmières à des institutions dont l'objet principal est l'éducation"—voilà ce que disait Bixler et Bixler dans un article publié dans le *Modern Hospital* de septembre, 1949, sur la formation des infirmières et il continue ainsi: "La moyenne des étudiants ne considèrent pas leur vie de collège comme une partie de plaisir mais ils pourraient dire que c'en est une en comparaison avec la vie que mènent les étudiantes infirmières. Les élèves sont lancées dans une série étoudissante de cours et de travaux de laboratoire. En plus, elles doivent apprendre de mémoire, parce qu'elles n'ont pas le temps d'assimiler autrement un imposant déploiement de termes et de procédés scientifiques."

Personne ne peut justifier ce bourrage de crâne durant le cours préliminaire dans nos écoles d'infirmières traditionnelles. Comme expérience pédagogique, elle est insoutenable.

En moyenne un tiers des élèves quittent l'école durant le cours préliminaire.

A quoi cela est-il dû? Est-ce au fait que l'on presse trop ces jeunes filles d'apprendre un programme qui est au-delà de leur capacité intellectuelle d'assimilation? Et cela dans un but tout autre que celui de donner une bonne instruction en nursing à ces élèves?

"On leur demande d'apprendre trop, dans trop peu de temps; il leur est impossible d'approfondir ce qu'elles ont appris. Elles se trouvent dans une situation compliquée et tendue où il est difficile pour une élève d'apprendre facilement à cette période d'adaptation."

En faisant cette suggestion—de confier la formation des étudiantes infirmières à des institutrices chargées de l'éducation—on ne veut pas détacher l'étudiante infirmière de l'hôpital. Les administrateurs et les directeurs d'hôpitaux doivent reconnaître que l'hôpital doit co-opérer avec ces institutions d'éducation en fournissant les ressources et la surveillance durant les expériences cliniques des élèves.

Avez-Vous Essayé Ceci?

Le système d'inter-communication entre le malade et l'infirmière évite bien de la fatigue et du va et vient dans les corridors de l'hôpital. Lisez à ce sujet le rapport de St. Barnabas Hospital, Newark, N.J., publié dans le *Modern Hospital* de septembre, 1949.

Nouvelles Méthodes en Administration Hospitalière

A la Cleveland Clinic on est à réaliser le programme suivant: Donner le meilleur service possible aux malades, on croit avoir atteint ce but. On a augmenté le nombre des infirmières graduées à peine du tiers puis on a créé deux nouveaux emplois—celui de hôtesse et celui de gouvernante (housekeeper)—dans le but de débarrasser les infirmières du travail de routine.

Le service des chambres voit à l'entretien des chambres et des salles des malades. La gouvernante reçoit chaque matin une liste, préparée par l'hôtesse, des malades ayant congé. Les devoirs de l'hôtesse sont de recevoir les malades, recevoir et transmettre les messages téléphoniques, et faire signer les reçus pour les fleurs ou autres objets. L'hôtesse voit aussi les parents, elle aide au point de vue arrangements financiers, et voit à ce que les lits dans les chambres et dans les salles soient libres le plus tôt possible. Il y a actuellement 20 hôtesses attachées à cet hôpital.

Un Internant pour les Gouvernantes de nos Hôpitaux

Un autre hôpital—Overlook Hospital, Summit, N.J.—dans le but d'enlever aux infirmières le travail de routine qu'elles ont à faire, a organisé un internat pour les gouvernantes d'hôpitaux. Voici comment Mlle Frances Penfield décrivit ce cours lors d'un congrès de l'American College of Surgeons: "Le cours est de six mois—de 8:00 a.m. à 4:00 p.m. Il y a trois heures d'enseignement théorique par jour et le reste du temps est employé à l'enseignement pratique sur les étages. On donne aux internes les connaissances sur l'économie domestique propre à l'hôpital, relation du personnel, analyse du travail, du temps, rapports entre les divers services, fourniture et équipement."

Le Même Problème Existe-t-il au Canada?

Toute personne s'intéressant aux infirmières devrait lire l'article paru dans *Good Housekeeping* du mois d'octobre et intitulé "Est-elle Vraiment une Infirmière?" Selon le Dr. Esther Lucile Brown, de la Russell Sage Foundation, qui a fait une étude sérieuse sur la profession d'infirmière aux Etats-Unis, n'importe qui peut revêtir un uniforme et s'appeler garde-malade aux Etats-Unis.

Dans cet article, il est dit que 280,000 infirmières enregistrées, ayant reçu une formation de trois à quatre ans, exercent leur profession mais, par contre, il y a environ 300,000 personnes, s'appelant gardes-malades, practical nurse, etc., qui soignent les malades sans posséder les connaissances les plus élémentaires du soin aux malades.

Sauf dans les états de New-York, l'Arkansas et la Louisiane, où on a sanctionné récemment des lois défendant à toute personne ne possédant pas une licence le droit de soigner les malades pour rémunération, il y a environ 45 états où toute personne, même sans aucune formation, peut s'appeler garde-malade et être payée pour ses services. Il y a lit-on encore dans cet article que plus de 300 cours présentés par des agences commerciales prétendant donner un entraînement rapide ou

un cours complet par correspondance. Une de ces agences a une graduation de 200 élèves par mois; une autre agence a accepté une élève le matin et l'a envoyé le soir chez un malade comme garde-malade.

Pour protéger le public, l'on recommande dans cet article que dans chaque état une loi soit adoptée, défendant à toute personne soignant les malades moyennant rémunération de le faire, sans avoir rempli un programme déterminé et sans avoir passé un examen. L'Association des Infirmières américaines a décrit cet article comme "un service extraordinaire rendu au public."

Going to Vancouver?

We are now in December—the month of holidays and Christmas-giving—but keep an eye on your budget! It is only six months to convention week, the week you want to spend in beautiful British Columbia.

The biennial meeting of 1950 will be held at the University of British Columbia in a setting different, yes, but duplicating the many factors that made the Mount Allison experience unique. All those who enjoyed the hospitality of the eastern university will know that they can look forward to an equally delightful atmosphere at the University of British Columbia. Tell your friends how much you enjoyed the last biennial and plan to bring a friend along with you to British Columbia. There will be many ways of getting there, none of them too expensive, and all presenting different charms. Information on rates, etc., will be available presently and will appear in the *Journal*.

The Work Conference

So much for the setting but, what about the meetings? We hope to have a surprise for you but it wouldn't be a surprise if we told you now. However, we can tell you that we are planning what we hope will be an even better *work conference program* than that presented in 1948 and which you were all good enough to vote a worthwhile experiment. Just a few lines then about the work conferences for those who did not attend before and to freshen the memory of those who did.

What is It?

What is a work conference? It is an experiment in the pooling of ideas. It affords opportunity to consider the effect new developments may have on the future of nursing. It is an attempt to enable nurses across Canada to exchange experiences, discuss problems and methods of solving them, and learn through interchange of experiences something of the rapid changes taking place in the health field. The time will be short—three half-days—but, with pre-convention preparation, we believe much can be accomplished.

How Does it Work?

How do we plan to develop these activities? Each conference will be directed by a team of consultants who are experienced in their field. In order that each group may come to grips with a specific problem difficult enough to be challenging, yet sufficiently limited to be workable, each work conference will be further subdivided into units small enough to lend themselves to active, informal discussion. These groups should not

be larger than from 12 to 18. Members will be expected to register for the unit within the conference which will be of greatest interest to them. Each unit will have a *chairman* with some skill in leading group discussions, an *observer* who will act as objective critic, and a *secretary* who will report to the larger group and prepare, each day, a summary which will be mimeographed and distributed to conference members.

The objective of a work conference is to afford opportunity to those interested in a particular problem to discuss its various phases in the hope that ideas will emerge that will help them find a solution.

Features of a Good Work Conference

(1) The agenda is planned with the help of those who take part. (2) Members come prepared to participate. (3) A corps of assistants acts as a service team to help conference groups reach high productivity. (4) A corps of assistants is trained prior to the meeting. (5) Time is taken to review progress. (6) Discussion groups are small and plans are made to keep total group informed. (7) Discussions aim at bringing participants' points of view into the open. (8) Groups analyze and improve own procedure. (9) Group accepts observer as a mirror of its own efficiency. (10) Group commits itself to carry out decisions made at conference.

The above-quoted 10 features of a good work conference are adapted from "Two Lessons of Group Dynamics" published by *Educator's Washington Dispatch*, Deep River, Connecticut, and may be purchased for 25 cents. Those who are interested in learning more about the conduct of work conferences would find this leaflet most helpful.

Staff Education Conference

We can now give you the names of the consultants for one work conference. We have been fortunate in securing for Staff Education: May Palk, educational director, Victorian Order of Nurses, Toronto; Gladys Sharpe, director of nursing, Toronto Western Hospital School of Nursing; Eileen Cryderman, director of nursing services, East York and Leaside Health Unit, Ont. With three such experienced consultants, this conference cannot fail to stimulate productive discussion on staff education. For those whose interests lie elsewhere, next month's *Journal* will have news.

Ontario

The following are staff changes with the Ontario Public Health Nursing Service:

Appointments: *Carroll Lindsay* (B.A.; Toronto Western Hosp. and University of Toronto certificate course) as senior public health nurse, Haldimand County school health service; *Adelin Graham* (St. Joseph's Hosp., London, and University of Western Ontario cert. course) Kingston board of health; *Jean Macfie* (Soldiers' Memorial Hosp., Orillia, and U. of T. cert. course) and *Elsie Turner* (Wellesley Hosp., Toronto, and U. of T. cert. course) Peel County health unit; *Beth McCallum* (U. of T. School of Nursing diploma course) Lambton health unit; *Laura Shepherd* (Saskatoon City Hosp. and U. of T. cert. course) Peterborough board of health; *Margaret Vail* (St. J. H., London, and U.W.O. cert. course) Middlesex County school health service; *Laura Wheelband* (Hamilton Gen. Hosp. and U. of T. cert. course) Halton County health unit.

Resignations: *Bernice Chalk* from Prince Edward County health unit; *Isabel Gleason* from Haileybury; *Dorothy Morrison* and *Mrs. George Herries* from Simcoe County health unit; *Mrs. Roy Ramsden* and *Mrs. Calvin Cupp* from Halton County health unit.

During the past year many subscribers have moved and forgotten to send us a change of address. If you do not receive your *Journal* regularly, **Please write us about it.**

Nursing Profiles

Mildred Irene Walker has been appointed nursing consultant with the Division of Industrial Health, Department of National Health and Welfare, Ottawa. A graduate of Victoria Hospital, London, Miss Walker holds her B.S. and M.A. degrees from Columbia University, receiving the latter in 1947 when she majored in personnel administration and guidance.

Following five years' experience in public health nursing, Miss Walker was appointed to the faculty of the Division of Study for Graduate Nurses at the University of Western Ontario. There she distinguished herself as a teacher and leader. During this period she found time for considerable activity with the nursing associations and was successively second vice-president, first vice- and president of the R.N.A.O.

Upon the completion of her advanced study in New York, Miss Walker decided to prove the value of personnel work by first-hand experience. Accordingly, she accepted an appointment as supervisor of health services with the Phillips Electrical Works Ltd. in Brockville, Ont. In leaving this position for her new work, Miss Walker feels that the nurse who has had public health nursing experience and training is well qualified to make a valuable contribution to the health and general well-being of industrial employees. She is looking forward to an expansion of this work on a national level.

MILDRED WALKER

Hester Janette Lusted has been appointed second assistant superintendent with the Victorian Order of Nurses for Canada with headquarters in Ottawa. A graduate in 1938 of the Regina General Hospital, and of the public health nursing course given at the McGill School for Graduate Nurses, Miss Lusted has served with the Victorian Order in staff and supervisory positions since 1942. She has been assistant district superintendent of the Ottawa branch for the past two years. Prior to that, Miss Lusted had opened a new branch at Port Arthur and had been nurse in charge of the Regina branch.

Newton, Ottawa

HESTER LUSTED

Marguerite May Fitzsimmons has been appointed assistant director of the public health nursing division of the Alberta Department of Public Health. Graduating from the Calgary General Hospital in 1943, Miss Fitzsimmons was awarded the Pattison Memorial Medal for proficiency in obstetrics. She received her public health nursing certificate from the University of Alberta and also has taken advanced work at the University of Toronto School of Nursing in administration and supervision in public health nursing.

Miss Fitzsimmons engaged in operating-

room work at the University Hospital, Edmonton, and in general duty at Drumheller before turning to public health nursing. More recently she was engaged in district nursing at Youngstown, Alta. For relaxation, she enjoys skating, tennis, and cycling. Miss Fitzsimmons has numerous other hobbies, including collecting gems of poetry.

Goerts, Edmonton

MARGUERITE FITZSIMMONS

Bessie Margaret Seaman has been appointed a National Office supervisor with the Victorian Order of Nurses for Canada. Born in Charlottetown, Miss Seaman received her B.A. degree from Dalhousie University, Halifax, before entering the school of nursing of the Montreal General Hospital where she graduated in 1928. For nearly a dozen years following graduation, during which time she secured her public health nursing certificate at Columbia University, Miss Seaman engaged in nursing activities in the United States, returning to Canada in 1941 when she joined the V.O.N. staff in Montreal. Two years later she was appointed nurse in charge of the Moncton branch and in 1944 was named district superintendent of the Saint John branch.

Miss Seaman has been very active in the affairs of the N.B.A.R.N. Latterly she has been chairman of their Educational Policy Committee and also of the Labor Relations Committee. Swimming, boating, and horse races provide Miss Seaman's out-of-doors enjoyment while reading, sewing, and knitting are her indoor hobbies.

Faye Saunders has succeeded Miss Seaman as district superintendent of the Saint John branch of the V.O.N. Miss Saunders had been on the staff of this branch for ten years so is no stranger to Saint John.

Born in Fredericton, Miss Saunders graduated from the Anna Jaques Hospital, Newburyport, Mass., in 1924. She remained on the supervisory staff there for two years, then engaged in private duty nursing for a year before joining the Victorian Order of Nurses. With them, she has also worked in Halifax, Lunenburg, and Digby. For the past two years she was professional reviewer of the Metropolitan Life Insurance Company records at the National Office of the V.O.N. She received her public health nursing certificate from the University of Toronto in 1945.

Instrumental and vocal music have claimed Miss Saunders' interest. She belonged to the Ottawa Choral Union and sang in a church choir. Sketching and weaving engross her in leisure hours. She is a member of the Canadian Guild of Weavers.

Horsdal, Ottawa

FAYE SAUNDERS

R. Pearl Sharpe, who has been superintendent of nurses at the Ontario Hospital at Whitby since 1936, has been transferred to a similar position at the Ontario Hospital in Cobourg. Miss Sharpe, who graduated from the Whitby hospital in 1927, and who had served there also as instructor and head nurse, has an enviable record of achievement. During and since the war, when staff shortages created such problems, Miss Sharpe often did double duty. This transfer to the less arduous tasks at Cobourg comes, therefore, as a reward of merit for the way in which Miss Sharpe has enhanced the reputation of the profession she serves so faithfully.

Margaret Stewart Fraser has retired

MARGARET S. FRASER

from the position she assumed in 1938 as superintendent of nurses at the Royal Alexandra Hospital, Edmonton. Graduating from there in 1920, Miss Fraser worked as a staff nurse for a year in Vermilion, Alta., before joining the teaching staff of the Vancouver General Hospital. After completing the work for her B.S. degree at Columbia University, she began teaching at Hartford (Conn.) Hospital, going to the Winnipeg General Hospital in 1931 and returning to R.A.H. in 1934. She became assistant superintendent of nurses in 1937.

Miss Fraser has always played a prominent role in nursing association activities. She has chaired numerous committees and was a vice-president in the Alberta Association of Registered Nurses. She received the King George V Jubilee Medal in 1935. She is a member of the University Women's Club, the Women's Canadian Club, and is a past president of the Soroptimist Club of Edmonton. Miss Fraser will reside in Edmonton for the present.

MARGARET MACINTOSH

Margaret Isabella MacIntosh has retired from her post as supervisor of the nurses' homes at the Royal Victoria Hospital, Montreal, after twenty-six years of devoted service. After graduating from R.V.H. in 1902, Miss MacIntosh had a full and varied career. Much of her work was at R.V.H. where at various times she was night supervisor or in charge of the outdoor department. During World War I she enlisted with the McGill Unit of the C.A.M.C. and was overseas for four years during which time she was mentioned in despatches. She spent the four years immediately following her return from overseas nursing in the United States.

One who has associated so long with nurses, especially student nurses, will have left many indelible impressions. To hundreds of nurses, Miss MacIntosh is a symbol of the dignity of nursing, coupled with a warm friendliness. Now that she has leisure to enjoy the good music, the theatre and, above all else, her church work, we all wish Miss MacIntosh many years of happiness. She will continue to reside in Montreal.

An adequate amount of illumination is one of the primary conditions of good lighting. If there is not enough light for the task, one must bring the eyes and the work closer together in order to see, resulting in eyestrain and ocular fatigue. The amount of light required depends on the person, the type of work being performed, and the surroundings. Standards of lighting have been developed which recommend the required light levels for various types of work.

The importance of contrast between an object and its background is self-evident. Black on white can be discriminated very well under low illumination, whereas low contrast work requires more light. This is readily exemplified by comparing the visual work required to sew with black thread on black cloth with that involved in sewing with the same thread on white cloth. In the first instance a great increase in illumination is necessary to offset the disadvantage.

Student Nurses

Psychoneurotic Components in Bronchial Asthma

HAZEL COLE

Average reading time — 7 min. 36 sec.

MR. RICE was transferred to the Allan Memorial Institute on August 24, 1949. He had been a hospital patient since August 5 and was being treated for bronchial asthma. This was his fifth hospitalization since December, 1948, and he was getting increasingly difficult to handle, demanding constant attention from the doctors and nurses and becoming disturbed if this was not given. His asthmatic attacks were also increasing in number and severity and adrenalin was no longer sufficient to relieve them. He expressed fear, anxiety, and a strong feeling of dependency, and appeared to be becoming a major psychiatric problem. He asked personally to see a psychiatrist. It was felt that Mr. Rice needed psychiatric as well as somatic treatment, and that this could be better undertaken at the A.M.I. He was followed by a psychiatrist for several weeks in the main building until a bed became available in the special division, at which time he was transferred.

Mr. Rice has always lived in Montreal. He is the only son in a family of five, one sister being older than he and three younger. His mother is evidently a very domineering and aggressive person who "rules the roost." He described his father as being like a "piece of putty." He expresses great admiration for his mother whom he says is a "brick." He is also very attached to his older sister, stating: "She fought all my battles for me and called me Richard the Rabbit-hearted; some day they will call me Richard the Lion-hearted."

This man is single, twenty years of age. He is thin and cyanotic in appearance, looking older than his years. He was forced to leave school after Grade X because of his health. He did clerical work for a time but this was very much below his aspirations for himself. He would have liked to have gone to college and taken up a profession, preferably medicine. Mr. Rice considers himself quite cultured, enjoys music and art, and at one time wrote poetry. These poems he felt were a part of him and not for publication; he might give them away but would never sell them.

His family appears to be of average means, although his mother works in the evenings as hostess in a restaurant in town. No doubt Mr. Rice's illness has been and still is a heavy drain on the family income. He has expressed anxiety over this at times.

He went out steadily for two years with a girl several years his senior, during which time he was relatively free from asthma. She left with her family to live in another town and he felt he had been "jilted." He then started having frequent asthmatic attacks again. This could be due to the loss of a mother substitute, which is significant in most asthmatics. His strong attachment to his elder sister and admiration for his mother should be noted in this relation too.

This patient has had a history of asthma for the past fourteen years.

Miss Cole is a senior student at the Royal Victoria Hospital, Montreal.

Onset was at the age of six, following whooping cough. His previous admissions were:

1938—Asthma
1938—Tonsillectomy
1938—Pneumonia
1945—Bronchoscopy
Jan. 1947 —Bronchial asthma, emphysema
Mar. 1947—Bronchial asthma, emphysema
July 1947 —Bronchial asthma, Loeffler's syndrome
May 1948 —Pericarditis with effusion
Dec. 1948 —Bronchial asthma, pulmonary emphysema, bronchitis acute. Urticaria, anxiety state.
Jan. 1949 —Bronchial asthma, pulmonary emphysema, pneumonia R.L.L.
April 1949—Bronchial asthma, pyrexia (unknown origin), periarteritis nodosa.
June 1949—Bronchial asthma, Loeffler's syndrome.

Between his discharge from hospital in January, 1949, and his readmission in April, Mr. Rice had several attacks of pneumonia. He was in bed all the month of March with rheumatic fever and then developed German measles. He was admitted to hospital again after this because of severe asthmatic attacks and pyrexia of unknown origin. When his temperature became normal and the asthmatic attacks had subsided to a large extent, he expressed the desire to go home, suppressing the fear of having a severe attack when at home. Almost as soon as he was home he began having more frequent and severe attacks which did not respond to adrenalin and the family doctor had to be called to administer aminophylline. He then began to run a fever and complain of severe pain in the left chest and was readmitted to hospital.

All this has a definite bearing on the patient's present illness, which is essentially a continuation of his first illness at the age of six. One can see by the impressive list of hospitalizations and diagnoses that Mr. Rice is a very sick man—physically as well as psychiatrically speaking. If the diagnosis of periarteritis nodosa is correct, his life expectancy is only about five years. At the present time he appears to be suffering from a recurrence of rheumatic fever and is on complete bed rest. An interesting feature is that, when suffering from another illness, the asthmatic attacks subside to a large extent.

Physical findings are: heart changes due to rheumatic fever, periarteritis nodosa, migratory bronchopneumonia, extreme emphysema, and some kidney damage (red blood cells and casts in a.m. urine). There are no physical findings, except for the emphysema, to explain the severe pain in the left chest of which this patient complains.

Mr. Rice has a pleasant and friendly manner though his facial expression is sad and anxious, with breathing labored. He becomes tense if under any stress and has had to leave a movie because his emotions precipitated an asthmatic attack. He appears anxious to co-operate but is very dependent on drugs and is inclined to ask for more than he needs.

Nursing Care

This patient is very thin, which worries him, so no special attention should be drawn to the fact. The nurse should see that his surroundings are as peaceful and pleasant as possible to offset an asthmatic attack He has a fairly good appetite when under no emotional stress.

Sleep is a particular problem, as Mr. Rice relies very much on sedation. He has an order for chloral hydrate gr. 7½ at bedtime, to be repeated in half an hour if necessary. The nursing problem in this respect is to have the ward quiet and to make sure that the patient is washed and ready for bed before giving sedation. Mr. Rice likes his light on as he is nervous in the dark; the nurse should not argue this point with him, as that would only make him hostile and less relaxed and prepared for sleep. She should take the positive attitude that she is sure he will sleep but also give him confidence that he can have the repeat order if he wants it.

Personal hygiene and elimination are no problems in this case. Mr. Rice takes pride in his appearance and is always neatly and appropriately dressed.

Protective Care

The routine psychiatric hospital precautions against suicide and accidents are taken. Mr. Rice is not potentially suicidal. The one thing he might do is to prolong an asthmatic attack to the point of near suffocation. This is not a great problem at the moment as he has an order for aminophylline gr. 7½ or 3¾ to be given intravenously q.4 h., p.r.n., and which he does not generally need so often. He also has an order for chloral hydrate gr. 7½ q.4.h. during the day, which he asks for when he feels himself becoming tense and anxious. So far his attacks have been controlled in this way before becoming very severe. If, however, at any time the aminophylline did not suffice, the doctor who had administered it would always be on hand to take the necessary steps and the nurse should be ready with oxygen and any medication he might need.

Leaving without permission does not present a problem, as Mr. Rice is anxious to co-operate and appears to be happy and satisfied with his treatment. He would also be too frightened to leave for fear of having a severe asthmatic attack—the thought of leaving probably would bring on an attack before he had a chance to escape.

The main problem in rehabilitation is this patient's reliance on drugs. If his asthma could be controlled by adrenalin, he would be able to look after himself. He has a great desire to be independent and is constantly referring, in terms of annoyance, to his great dependency on other people. We are trying to get him back on adrenalin and he is co-operating to a great extent. When he was up, he socialized fairly well with the other patients, attended the movies, took an interest in ward activities, and had started to work at occupational therapy. In this way he is preparing himself to meet some of the problems that will face him in the outside world.

Treatment

Mr. Rice is receiving psychotherapy from Dr. X. This is on a rather superficial level, the main aim being for him to be able to relate himself to Dr. X and thus gain support and assurance. The idea is never to directly refuse him aminophylline. If he wants it he can have it and, after being assured of this, the patient said, "O.K. Doc, now I won't need as much." Mr. Rice seems to have gained something from this treatment, as he pleaded to stay here rather than be transferred back to the main hospital when the symptoms of rheumatic fever recurred. The nurse should remember that she is a mother figure and, therefore, try to be stable and reasonably permissive and, above all, not to reject him.

Insulin therapy was tried for a short time but was discontinued as it caused asthmatic attacks. Medications are: dilantin gr. 1½ b.i.d. and chloral hydrate gr. 7½ q.4.h., p.r.n. and h. s., repeating once in half an hour, if necessary, for sedation. Aminophylline gr. 7½ or 3¾ q.4.h., p.r.n., and adrenalin, 1:1000, minims $\overline{V}$ or $\overline{X}$ to relieve asthmatic attacks. Acetyl salicylic acid gr. XV q.3.h. with amphojel dr. 2 is given for relief of rheumatic fever. Elixir B complex dr. 3 q.i.d. is also ordered.

The future care of this patient involves treatment of his physical symptoms, which are serious and not likely to be cured to any appreciable extent. From the psychological angle he should be given psychotherapy with a view to making him more self-assured and less dependent. He should gain this by first getting support from the therapist.

The doctor's diagnosis is bronchial asthma with psychoneurotic components. Owing to his physical condition the prognosis is very poor.

I have learned many interesting points, both medical and psychiatric, from the study of this patient. It impressed on me the importance of treating a patient as a whole.

Hysteria

JEAN JULEFF

Average reading time — 4 min. 48 sec.

MRS. EGAN was admitted to the public medical ward at eight one evening. She was 60 years of age, about five feet two inches tall. She had a ruddy complexion, grey braided hair, and large brown eyes. Her body was firm and appeared healthy. She was of average intelligence but had had very little schooling. She was born in England of very strict parents, and had worked as a children's nurse until she was 25, when she left home to seek adventure in Canada. It was not long after her arrival in Saskatchewan that she married a man whom she now claims she never loved.

Evidently this was the beginning of Mrs. Egan's present illness. Her husband was a diabetic, and as years passed he became bad-tempered, cruel, and very dictatorial. To add to this problem he developed a gangrenous leg which eventually had to be amputated. Soon afterward, they moved to British Columbia where Mrs. Egan provided the only financial support by doing housework and by washing dishes in cafes. When her day's work was done she returned home to the bickering and ill-tempered blows from her husband. Through constant abuse, she gradually became nervous and timid, losing all the self-confidence that she had possessed. Finally she began having spells of dizziness, fuzziness of vision, and was unable to maintain her equilibrium. These spells increased in severity until she was afraid to walk across the street alone. The crisis was reached one day when she collapsed on the street and passers-by took her to a doctor's office. After a brief examination, the doctor, realizing that she needed immediate care, sent her into the hospital. His tentative diagnosis was a neuro-motor disturbance, perhaps a brain tumor.

Mrs. Egan was extremely shy and very nervous, having never been to a doctor or in a hospital as a patient before in her life. She was afraid of all treatments, especially hypodermics. She complained of blurred vision, vertigo, frontal headache, and vomiting. She had a tendency to burst into tears at the slightest provocation. This, of course, could have been due to nervousness; whereas the other symptoms, as indicated by the doctor, could be due to a neuro-motor disturbance.

Treatment was limited at first while she was under observation. However, she was given penicillin 20,000 units every three hours to offset any possible infection present; betalin complex intramuscularly daily for vitamin B deficiency; aminophylline as a diuretic; caffeine sodium benzoate to relieve the vertigo and headache; and a number of sedatives to promote rest and comfort.

Laboratory tests of all kinds were done but all proved completely normal. A chest x-ray showed a definite cloudiness, but a second one a week later showed that the peribronchial congestion had cleared. An x-ray of the skull showed no pineal displacement. These tests proved that there was no direct evidence of a brain tumor.

Four days after Mrs. Egan's admission, her husband died suddenly of a heart attack. Her reaction appeared to be not of sorrow but of relief. From that day on, a great personality change took place in our patient. Her outlook on life was much happier. She began to make friends with the nurses and patients and to plan for the future. She gradually improved and was able to be up and around, becoming the centre of any activity among her newly found friends.

In the meantime, the doctor had

Miss Juleff's experience in caring for this patient was gained as a student at the Royal Columbian Hospital, New Westminster, B.C.

called in three specialists. The first, a neurosurgeon, found no evidence of neuropathology other than perhaps some arteriosclerosis of the cerebellum. He suggested that a neurologist be consulted.

The neurologist examined our patient throughly and found that there was a hysterical basis for memory loss, visual disability, motor and sensory nerve reactions, and coordination. There was a complete absence of any vibration sense, even on the skull, which would suggest hysteria. The final diagnosis was psychoneurosis—hysteria.

The district neurologist agreed with the above diagnosis and felt that Mrs. Egan's outlook on life seemed to be completely changed, and, there being no further need for retreat from reality, she was ready to take up life anew.

With his daily visits and cheerful advice, Mrs. Egan's doctor helped restore her self-confidence and faith in humanity. She began giving both the doctor and nurses further information as to her past which verified a background leading to hysteria. There were times, of course, when she became difficult to handle. She demanded attention and, if she did not receive it, felt she was being ignored or mistreated. She then became persecutory and suspicious, condemning the nurses and patients alike. This required tactful nursing care, not too much sympathy, but strong, firm reassurance.

As time passed Mrs. Egan became stronger, her symptoms subsided. Under the care of a nurse she began taking long walks in the afternoons and even attended a few shows at the local theatre in the evening.

In the meantime the doctor called in the social worker to assist in planning Mrs. Egan's return to home and community. Finally she was discharged from hospital, not completely cured, but in the right environment with its associated freedom, friends, and independence, we feel sure that she will find peace and happiness in this new chapter of her life.

Britain's State Health Service

LAURENCE DOPSON

Average reading time — 7 min. 12 sec.

BRITAIN'S NATIONAL Health Service, which provides free treatment for everybody, came into operation on July 5, 1948. It is proving extremely expensive. The cost up to the end of the first nine months of the service was about £259,750,000, which is considerably more than twice as much as had been expected. Particularly popular has been the supplementary ophthalmic service, which provides free spectacles. As a result of the great demand, the delay in supplying spectacles in ordinary cases is about three months. Increased demands have also led to some shortage of x-ray film. Mr. Bevan, Minister of Health, has arbitrarily cut the remuneration for dentists; the fees of opticians and opthalmologists have also been reduced; and hospitals have been asked to cut their expenditure. Approximately 93 per cent of the population has registered with doctors under the service, and most doctors have joined.

The health service in England and Wales, and in Scotland is separate, but it follows broadly the same pattern in the both areas. Over all is the Minister—the Minister of Health, in England and Wales, and the Secretary of State for Scotland, in Scotland. To advise the Minister is a Central Health Services Council appointed by him. The law requires that two members of this Council

Mr. Dopson is an on-the-spot observer, being resident in England at the present time.

shall be nurses and one a midwife. There are standing advisory committees, including members who are not on the Central Health Services Council itself. These include standing advisory committees on nursing, maternity, and midwifery. In each area there is an executive council responsible for non-hospital services, including supplementary ophthalmic services, pharmaceutical services, and the general practitioner service, although the doctors have a local medical committee which the executive council consults. There are also medical practice committees which regulate the entry of doctors into the service. A doctor will be refused entry in an area which is considered "overdoctored," so that he cannot practise in the service where he likes. The buying and selling of practices is prohibited. Local authorities still provide certain services, including home nursing, health visiting, and non-hospital maternity services and child welfare. They will also be responsible for setting up health centres in England and Wales. Much has been said about these centres, which will provide separate consulting rooms for doctors who will share certain facilities. No such centres have yet been constructed and large-scale building is hardly likely in Britain's present economic state, though plans for some centres have been drawn up.

It is, however, with hospitals that nurses are most concerned. Practically all hospitals come under the state in this scheme (a few have been disclaimed, including Catholic hospitals and one hospital maintained by the trade union movement). This includes medical teaching hospitals, although these in England and Wales, but not in Scotland, remain under separate boards of governors (appointed by the Minister). The effect of this is that all medical teaching in Britain is now carried out in state institutions by state servants. Those institutions are the same as before and the servants are the same professors, but it is a situation which gives rise for thought.

Britain has been divided into a number of large regions, for hospital purposes, each region being generally based on a medical teaching centre. Responsible for the hospitals in each region is a regional hospital board, again appointed by the Minister, after consultation with various organizations, whose nominations for membership he is not, however, bound to accept, nor has he always done so. On each board has been appointed at least one nurse. These boards coordinate the hospital services over the whole region; they are, in fact, the overall planners. They appoint hospital management committees which are responsible for the day-to-day management of individual hospitals. These hospital management committees usually control not one but a group of hospitals, and the group is not confined to one type of hospital. The budget of the hospital management committee has to be approved by the regional board. Hospital nurses are under contract to the regional hospital board but are appointed by the individual hospitals. Most regional hospital boards have appointed a regional nursing officer. It need hardly be said that the final pattern of the hospital and nursing services has not yet evolved. In respect of nursing it may be noted that the whole system of training, etc., is to be re-organized, but legislation on this has not yet been published.

It will be seen that virtually all practising nurses are participating in Britain's national health service and thus come under the state, either directly or indirectly. Although most nurses in Britain prefer, as professional persons, to be members of a professional organization, some belong to a trade union. Perhaps the socialist party would like to see them all do so, but the government has repeatedly recognized that nurses have a right to join a non-political professional body if they wish. The Minister hopes, however, that every nurse will join some sort of organization. The nurses and midwives functional Whitley council has already considered and settled a number of matters

relating to pay; less is known about its work in regard to other matters, but it is known, for instance, that it decided there should be no alteration in existing local arrangements agreed to in individual hospitals until national arrangements had been made.

How does the national health service affect the patient? Anyone can take advantage of the service, whether they pay insurance contributions or not, although all adults are compelled to pay such contributions, unless exempt in special cases, such as students. A person may use one part of the service and not another, as he pleases. He may go to a doctor under the scheme but prefer to go to a dentist privately, for instance. He may prefer not to use the scheme at all, although he will still have to pay for it through insurance contributions and taxation. A person may still pay for a private room in a hospital if he wishes, and provided the room is not wanted for a state patient who needs it for medical reasons, but the price of such private accommodation has been increased very considerably. A person having glasses under the scheme has a choice of ten different types of frames which are entirely free, and he may have one of nine others on payment of an extra charge. If, however, he wishes to go outside these ranges, he must pay for both frames and lenses, although the sight-test itself has still been free. The Minister refuses to make what he calls "grants-in-aid." If a person goes to a doctor privately, he cannot obtain the medicines prescribed under the state pharmaceutical service, so that he has to pay for medicines as well. The Minister has declared that it would be administratively impractical to do otherwise, but has also made it clear that he hopes people will realize the wisdom of not encouraging private practice.

There is no doubt that the service has provided a welcome help for persons who, for instance, need a long course of expensive medicines. There are conflicting reports as to whether it is being abused and if so to what extent. Certainly there is a temptation to feel "I must get something out of this" and people are coming for "certificates" to get things free which they would not have thought twice about paying for. On the other hand, people who would have delayed seeking medical advice on account of the cost previously are now coming forward earlier, and this is a good thing.

So far as doctors are concerned, the scheme has meant, among other things, a great increase in work, including paper work.

Although one does not have to pay when one goes to see one's doctor, or when one presents his prescription to the chemist to be made up, clearly it all has to be paid for somewhere by someone. The cost is partly met out of insurance contributions by those who pay them. Everyone, except children, old people, housewives, and certain minor exceptions, has to pay national insurance contributions, irrespective of their income or of whether they wish to participate in the health service or not. These amount to 3s. 10d. a week for an employed person. A self-employed person pays more—5s. 1d. a week—and receives less benefit. These national insurance contributions cover unemployment benefit and old age pensions, so that only a part of the considerable sum paid by individuals directly each week goes towards the health service. As has been indicated, the cost of this service is considerable and mounting, although it must be remembered that money would be spent on health services anyway, whether they are under the state or not. Apart from insurance contributions, the money for the state health service comes from rates and taxes, so that practically everybody pays something for what they receive free, the incidence being highest, of course, among those earning the most.

There was considerable opposition to the form of the health service and difficulties have undoubtedly arisen. How the scheme will shape ultimately, whether the service will fulfil the very

generous expectations which its enthusiasts held out, or will in fact mean the moral and financial ruin of the country, as some foresee, will have to be seen. That this experiment will have a profound influence on medicine is certain. It would also appear clear that, whatever critics may say, there can be no going back on what has been done.

Streptomycin Trials

TREVOR WILLIAMS

Average reading time — 4 min. 12 sec.

Streptomycin is of undoubted benefit to sufferers from pulmonary tuberculosis. This information has been arrived at after extended tests by Britain's Medical Research Council—tests which the *British Medical Journal* regarded as a model for the solution of kindred problems.

For the past few years streptomycin has figured in the newspapers as a cure for tuberculosis. Reports in medical journals, from which the popular accounts were gleaned, have, however, been conflicting. Sometimes streptomycin appeared to effect remarkable cures; at other times physicians reported not only no improvement in their patients but the appearance of alarming symptoms, such as nausea and deafness, due to the drug itself. As tuberculosis is one of the most deadly of scourges to which the human race is subject, the medical profession, and no less the general public, have been eagerly awaiting a really clear statement of what the new drug can do. The first definite answer has now come as a result of most elaborate clinical trials completed in seven of Britain's hospitals. The verdict of the experts, who organized the trials and carried out the treatment, is that although streptomycin is not a spectacular cure, it is beyond doubt of value in treating pulmonary tuberculosis.

The story of streptomycin is in a sense a companion chapter in the penicillin story. At quite an early stage in their investigations, British workers discovered that penicillin is extraordinarily active against many kinds of bacterial infection but quite inactive against others. Outstanding among these, because of the heavy toll it takes of human life and happiness, is tuberculosis. The tubercle bacillus thrives in the presence of concentrations of penicillin hundreds of times greater than those needed to kill other microbes, such as the staphylococci.

This and other limitations in the power of penicillin encouraged research workers throughout the world to see whether moulds or similar antibiotic substances could produce drugs different from penicillin. Thousands of different moulds were collected—from such varied sources as the soil-decaying fruit and even from the air—and cultivated in the same way as the mould *penicillium notatum* was being cultivated for the manufacture of penicillin. Hundreds of the moulds were, in fact, found to produce substances deadly to the germs of disease and it seemed that a veritable treasure house of new drugs had been opened. Hopes were soon blighted, however. Detailed investigations showed that many anti-bacterial substances which looked so promising could never be used in medicine. The majority failed for the simple reason that, although they were deadly to the germs of disease, they were equally deadly to the cells of the human body. They were, in fact, general poisons, whereas what was needed was a specific poison, something which would destroy bacteria—especially those which resisted penicillin—but be innocuous to the human body.

Among the score or so of these mould products is streptomycin. This substance was discovered in 1944 after lengthy investigations by Professor S. A. Waksman in New Jersey, who obtained it from a mould growing in soil, and almost at once it attracted wide attention. First and foremost, it was active against organisms—especially the tubercle bacillus—which penicillin would not touch. Second, it seemed to fulfil the other requirement of being not dangerous but only unpleasant to human beings. Preliminary tests with guinea pigs infected with tuberculosis were most promising.

Very soon streptomycin was being made in sufficient quantities to use it against tuberculosis in human beings, but the results were

very controversial. The biggest difficulty was due to the nature of the disease itself. It commonly develops quite slowly, so that even under the best conditions, months or even years are needed to see whether any particular drug is beneficial or not. Secondly, and a most confusing factor, patients quite often show great improvement, with no more treatment than rest in bed. If such patients have been receiving streptomycin or any other drug, the recovery may quite wrongly be attributed to the drug instead of being recognized as an act of nature.

In September, 1946, the Medical Research Council in London formed a "Streptomycin in Tuberculosis" Committee, which determined to find out just how many of the claims made for the drug could be justified. First, they selected a particular kind of tuberculosis—tuberculosis of the lungs. In the seven hospitals taking part in the trials, 107 patients of similar ages (15 to 30 years old) were selected who showed as nearly as possible the same symptoms of the disease. Of these, 55 were treated with streptomycin. The other 52 received exactly the same nursing treatment except that they were given no streptomycin. Elaborate precautions were taken to see that radiologists and other experts who had to assess the condition of the patients every month did not know which were streptomycin cases and which were control cases. It was feared that quite unconsciously this knowledge might influence their judgment.

Results showed that streptomycin is of undoubted benefit to sufferers from pulmonary tuberculosis. But they also showed that numerous problems concerning the use of the drug still await solution. These problems, however, are now much less formidable, for the report shows that the elaborate precautions recommended by theory worked perfectly in practice.

One complication in treatment was found to be that in some patients the tubercle bacilli gradually became resistant to streptomycin so that the drug lost its potency. The committee undertaking the tests, therefore, urges the need to begin treatment only at the critical moment in the development of the disease.

This painstaking investigation will be welcomed. At last we have a clear indication both of the limitations and possibilities of streptomycin.

Book Reviews

Safeguarding Motherhood, by Sol T. DeLee, M.D. 135 pages. Published by J. B. Lippincott Co., Medical Arts Bldg., Montreal 25. 1949. Illustrated. Price $2.50.

Reviewed by Christine Charter, Assistant District Superintendent, Vancouver Branch, Victorian Order of Nurses.

As long as thousands of expectant mothers fail to take advantage of the prenatal guidance so essential to saving life and preventing suffering there will be a need for the type of book Dr. DeLee has written.

Student and graduate nurses engaged in institutional and public health activities should welcome "Safeguarding Motherhood" for at least two reasons: It provides a combination of clear, concise information with a sound psychological approach for the expectant mother herself. It will help nurses to enjoy teaching the individual or the group because it anticipates and answers so many of the sometimes puzzling questions asked by mothers-to-be.

The volume is divided into ten sections. Of these, two are particularly outstanding in their presentation of material which has frequently been lacking, or too brief, in the literature available to expectant mothers: the chapters on the anatomy and physiology of reproduction and the labor supplement—clear and reassuring information with excellent illustrations and diagrams.

From the point of view of the nurse more emphasis could well have been placed on the value of team-work between the patient, the doctor, and the nurse. However, "Safeguarding Motherhood" may be recommended as an attractive little book and a sound supplement to the advice of the physician.

Medical & Nursing Dictionary and Encyclopedia, by Evelyn Pearce. 723 pages. Published by Faber & Faber Ltd., London, Eng. Canadian agents: British Book Service (Canada) Ltd., 263 Adelaide St. W., Toronto 1. 9th Ed. 1949. Price $4.50.

Reviewed by Helen E. Warner of Niagara Falls, Ont.

This book is an inexhaustible source of information with topics covering every detail of the busy nurse's activity. The clear, concise explanations of various techniques relating to the administration of drugs and general nursing care are easy for one to comprehend since they follow through to the last detail.

For nurses who have been away from active duty for any length of time, this book will be most helpful in organizing their thinking and work to meet the present-day trends.

Mayo Clinic Diet Manual, by The Committee on Dietetics of the Mayo Clinic. 329 pages. Published by W. B. Saunders Co., Philadelphia. Canadian agents: McAinsh & Co. Ltd., 388 Yonge St., Toronto 1. 1949. Price $4.40.

Reviewed by Sister Frances Loyola, Nutritionist, Charlottetown Hospital, P.E.I.

The preface of this manual tells us that "the dietary procedures were developed for the guidance of physicians, fellows, dietitians, and the dietetic internes and nurses of the Mayo Foundation, the Mayo Clinic, and the hospitals of Rochester, Minn." Because of numerous requests for mimeographed copies it was decided to print the dietary lists—all of which were agreed upon by special committees and then given trial in dietary departments of the associated hospitals. They come to us now after being subjected to the test of practice. The diets are described in technical terms, designed for use by persons with training in medicine or dietetics, and are not intended for direct distribution to patients.

The Manual has 30 major headings regarding special diets, standard diet lists, special test procedures, and an appendix providing ready reference on content of foods. A first inspection gives the impression that the therapeutic diets are complicated compared with the 12 standard diets outlined by the American Dietetic Association; more careful study shows they are detailed developments of the 12 basic diets.

"The proof of the pudding is in the eating"—this adage is particularly applicable in judging a diet manual, for only by using it can we evaluate it. Our hospital dietary practices are marked by a lack of uniformity, but most dietitians will welcome a reference manual with the prestige of the Mayo Clinic behind it. The technical terms of the Manual are not so complicated that the average nurse (who may have forgotten most of what she learned in dietetics) will be puzzled by the lists given. The approximate measures listed make for convenience when no gram scale is available. The comprehensive lists of goods included and excluded on low sodium diets add special value to this book since these diets are now so much in vogue.

Anesthesia: Principles and Practice—A Presentation for the Nursing Profession, by Alice M. Hunt, R.N. 148 pages. Published by G. P. Putnam's Sons, New York. Canadian agents: McAinsh & Co. Ltd., 388 Yonge St., Toronto 1. 1949. Illustrated. Price $2.90.

Reviewed by Hilda C. Adams, Instructor in O.R. Technique and Anesthesia, Winnipeg General Hospital.

Since it is not the practice in Canada for nurses to give anesthetics, this book is a little too detailed for student nurses, except as a reference text. The chapter on pre- and post-operative care of the patient is particularly good. Some of the points are contrary to our ways of teaching but it is always well to learn how it is done elsewhere.

Curare is a comparatively new drug and there is very little literature available on it. Miss Hunt's chapter about the drug is very enlightening and easy to understand.

For nurses who are going into small hospitals, where there is only one doctor, who starts the anesthetic and then expects the nurse to carry on while he does the surgery, this little book would be an excellent guide. In hospitals where the operating-room supervisor gives lectures on anesthesia, the text will be of great value to either teach from or to use as a reference book.

Chemistry in Nursing, by Raymond E. Neal. Published by McGraw-Hill Co. of Canada Ltd., 50 York St., Toronto 1. 1948. Illustrated. Price $4.20.

Reviewed by Jean G. Church, Instructor, Nova Scotia Sanatorium, Kentville.

The author states in the preface that a survey of existing chemistry textbooks for nurses discloses two types—those which go beyond the needs of the student and those which are reduced to a bare outline of the essential facts. In this text Professor Neal is attempting to avoid both extremes.

The book is organized in sixteen units,

each one followed by review questions and laboratory exercises. There is a 50-page appendix with such valuable teaching aids as lecture outlines, suggestions for demonstrations, materials for experiments, and a list of good films. The instructor should find this a most valuable textbook, but its actual value to the student is questionable, depending on the student's background in science and on the length of time available for the course. It is a lengthy book and some of the material is quite advanced for the student in a basic nursing course.

In the foreword to the instructor, the author suggests that, if the course is too long, six of the thirty-two chapters may be eliminated without interrupting the continuity of the book. These chapters and some of the early material in organic chemistry should be omitted for, in my opinion, there is too much detail on subject matter which is not essential in nursing—e.g., valence, ionization, the detailed chemistry of sulphur.

The chemistry of carbohydrates, fats, and proteins is discussed fully and serves to round out the courses in nutrition and physiology. Unfortunately, the author does not include a discussion of the chemistry of vitamins, enzymes, or hormones. If these had been included, the reader would have a broader picture of digestion and metabolism.

The book has many fine features. The style is interesting. The examples are excellent. The footnotes and cross-references are cleverly planned. All of these are features which make this a most readable science textbook. To many nurses, chemistry is dull and dry and it is a problem for the instructor to make the course alive and interesting. In this respect, particularly, the book is highly recommended because the author uses practical, everyday examples and, whenever possible, he brings out points which have a direct bearing on nursing.

This is an excellent reference textbook and should be a valuable addition to the school library.

Neurological and Neurosurgical Nursing, by C. G. de Gutiérrez-Mahoney, M.D. and Esta Carini, R.N., B.S. 516 pages. Published by the C. V. Mosby Co., St. Louis. Canadian agents: McAinsh & Co. Ltd., 388 Yonge St., Toronto 1. 1949. Illustrated. Price $6.25.

Heretofore, when one wished some reference material on this important branch of nursing service, it was necessary to compile reading lists from suitable magazine articles. Textbooks were written largely on the medical practitioner's level. Here is a text for nurses, written by authorities who have had broad experience in this field. Dr. de Gutiérrez-Mahoney was senior neurosurgeon with the United States Army Air Forces and is director of the Neurological Division and neurosurgeon-in-chief at St. Vincent's Hospital, New York City. Miss Carini is clinical instructor of neurological and neurosurgical nursing at the same institution.

"The more common neurological diseases (developmental, degenerative, infectious, convulsive, vascular, neoplastic, and traumatic) and their medical and surgical treatment are discussed. The preoperative and postoperative nursing care have been analyzed and developed as follows: the observation of the patient, his environment, instruction, position and activity, hygiene, nutrition, elimination, prevention of complications, diversion, and physical and psychological rehabilitation." It will be seen from the foregoing that the text covers the essential topics very thoroughly; yet the information is set down in such orderly fashion that it is readily accessible to the student who wants to know, step by step, what procedure should be followed.

The anatomy and physiology of the nervous system is carefully reviewed to bring the nurse assigned to this service up to the minute in her knowledge. In the chapter on the admission and discharge of patients, the authors stress the importance of complete rehabilitation plans: "The responsibility for the patient's care is not ended with his discharge, but should be assumed until the patient no longer needs any of our help or supervision."

Numerous illustrations add to the clarity of the explanations.

A course outline which provides for 92 hours of organized instruction and 292 hours of supervised student experience is appended. This text will be welcomed for both undergraduate and post-graduate student programs.

They do certainly give very strange and new-fangled names to diseases.

—PLATO, 405 B.C.

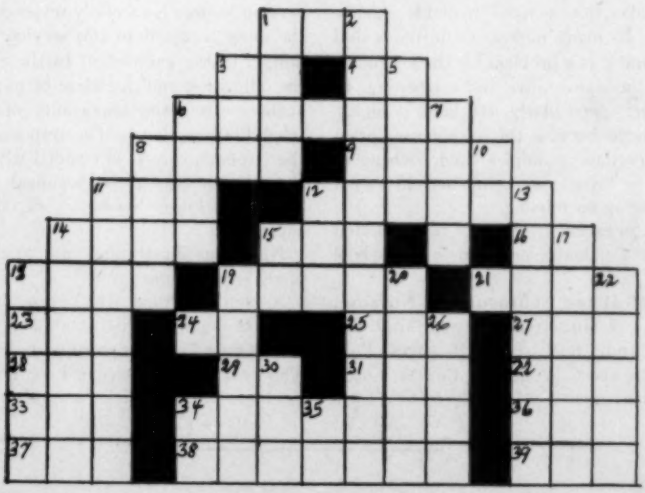
Crossword Puzzle Page

ACROSS

1. An abbreviated medical student.
3. The beginning of a company.
4. I am, thou art, he —.
6. Proceed from.
8. Helps the blind.
9. Equal feeting.
11. A critic before tea.
12. Awful to take but so effective.
14. Co-discoverer of insulin (1st name abbr.)
15. A rushing torrent in spring.
16. Part of a butter substitute.
18. A bitter thing your echo calls back.
19. Nurse's daily record.
21. An easy way to give medicine.
23. Grass cutting.
24. Ana (abbr.)
25. As the poet said before.
27. The only.
28. Pro re nata.
29. A little bit of scandal.
31. Start a solo.
32. Annoy thus.
33. Only a little white one.
34. A limelight for sports.
36. It's Greek to me.
37. Finis.
38. What the nurse's aide does.
39. Cut a relative short.

DOWN

1. Where Moses was buried.
2. Highbrow perspiration.
3. Nine hundred and one.
5. Remain.
6. A lady's name.
7. Once upon a time.
8. North American Indian.
10. When the senorita says yes.
11. King George was in 1937.
12. Innermost lining of cranium.
13. A necessity at an inquest.
14. Rare, even in the sterling bloc.
15. Important blood factor.
17. Woolly.
18. Plenty, believe me.
19. A close partner to fractures.
20. It may be speckled.
22. According to the law.
26. Trees, plentiful in Ont. and Que.
30. Children's Aid Society.
34. Abbreviate the angle between radius fixus and a line joining basion and staphylion.
35. A double prefix.



(*Solution on page 938*)

British Columbia

The following are appointments, transfers, and resignations occurring on the staff of the public health nursing service, British Columbia Department of Health and Welfare:

Appointments: *Margaret Campbell* (Vancouver General Hosp. and B.A.Sc., University of B.C.; M.P.H., University of Michigan) as assistant director, public health nursing service; *Barbara Smith* (Royal Columbian Hosp., New Westminster; U.B.C. public health nursing course; University of Toronto supervision and administration course) as district supervisor, Matsqui-Sumas-Abbotsford public health service; *Margaret Cammaert* as supervisor, West Kootenay area.

Helene Boehme (Regina Gen. Hosp. and U. of T. p.h.n. course) to Smithers district; *Edith Bowron* (St. Paul's Hosp., Saskatoon, and U.B.C. p.h.n. course) to Mission district; *Helen Byrt* (University Hosp., Edmonton, and U. of Alta. p.h.n. course) to Salmon Arm, North Okanagan Valley health unit; *Olive Clancy* (R.C.H., New Westminster, and U.B.C. p.h.n. course) to Surrey; *Marjorie Craik* (Moose Jaw Gen. Hosp. and U.B.C. p.h.n. course) and *Pauline Pearson* (St. Joseph's Hosp., Victoria, and U.B.C. p.h.n. course) to Chilliwack, Upper Fraser Valley health unit; *Marjorie Croft* (U.H., Edmonton), *Anna K. Jones* (Belleville Gen. Hosp. and U. of T. p.h.n. course), *Olive Smith* (Toronto Gen. Hosp. and U. of T. p.h.n. course), and *Isla Tuck* (Hosp. for Sick Children, Toronto, and U.B.C. p.h.n. course) to Saanich and South Vancouver Island health unit; *Viola Davies* (V.G.H. and B.A.Sc., U.B.C.) to Port Alberni, Central V.I. health unit; *Lona Dean* (V.G.H.) to Courtenay; *Mary Farquharson* (V.G.H. and U.B.C. p.h.n. course) and *Jessica Field* (Royal Alexandra Hosp., Edmonton, and U.B.C. p.h.n. course) to Nanaimo, Central V.I. health unit; *Elin Godber* (Winnipeg Gen. Hosp. and U.B.C. p.h.n. course) and *Jean McAllister* (V.G.H. and U.B.C. p.h.n. course) to Trail; *Dora Lequesne* (V.G.H. and B.A.Sc., U.B.C.; M.A., New York University) to Lillooet.

Janet MacLennan (Montreal Gen. Hosp.) to Maple Ridge; *Alice MacNaughton* (T.G.H. and U.B.C. p.h.n. course) to Powell River; *Kerstin Nelson* (St. J. H., Victoria, and McGill University p.h.n. course) to Abbotsford; *Shirley Norwood* (Royal Inland Hospital, Kamloops) and *Betsy Quayle* (R.C.H., New Westminster, and U.B.C. p.h.n. course) to Kamloops; *Alvera Paterson* (Royal Jubilee Hosp., Victoria, and U.B.C. p.h.n. course) to Vernon, North Okanagan Valley health unit; *Estelle Robinson* (V.G.H. and B.A.Sc., U.B.C.) to Williams Lake, Cariboo health unit; *Pauline Siddons* (Saskatoon City Hosp. and U.B.C. p.h.n. course) to Keremeos; *Amy Smith* (V.G.H. and B.A.Sc., U.B.C.) to Cumberland; *Sheena Smith* (R.J.H., Victoria, and U.B.C. p.h.n. course) to Ashcroft; *Elizabeth Stewart* (H.S.C., Toronto, and U. of T. p.h.n. course) to Duncan, Central V.I. health unit; *Irene Wallace* (Herbert Reddy Memorial Hosp., Montreal, and B.N., McGill University) to Kelowna, South Okanagan Valley health unit.

Transfers: *Marion Bellis* from Ashcroft to Haney; *Aileen Bond* from Lillooet to be senior nurse of Peace River health unit; *Doris Brentzen* from Cariboo health unit to Creston, East Kootenay health unit; *Lorraine Carruthers* from Saanich and South V.I. health unit to open new public health nursing district of Howe Sound at Squamish; *Jeannine Coupal* from Prince Rupert to Langley district; *Dorothy (Morris) Dando* from Saanich and South V.I. health unit to Gibsons; *Phyllis Dangerfield* from Central V.I. health unit to Ladner; *Mary Greenfield* from Duncan to Fort St. John, Peace River health unit; *Freda Hilton* from Haney to be senior nurse with Prince Rupert health unit; *Signe Johnson* from Ladner to Penticton, South Okanagan Valley health unit; *Margaret Lattimer* from Peace River health unit to Duncan, Central V.I. health unit; *Elizabeth Layton* from Chilliwack to Vanderhoof; *Shirley Main* from Nanaimo, Central V.I. health unit to Prince Rupert; *Mary McKinlay* to be senior nurse at Prince George; *Joan Morison* from Central V.I. health unit to Revelstoke; *Dorothy Neuman* from Revelstoke to open Kettle Valley public health service at Greenwood; *Hazel Provins* from Haney to Child Guidance Clinic, Vancouver; *Gladys Skinner* from Cumberland to Division of V.D. Control; *Frances Stewart* from Ladner to Powell River; *Jessie Urie* from Trail to Hope district in Fraser Canyon area; *Grace White* from Kelowna, South Okanagan Valley health unit to be senior nurse with North Okanagan Valley health unit.

Resignations: To take public health nursing certificate course at U.B.C.—*June Cornell* from Powell River; *Dorothy Deeble* from Penticton, South Okanagan Valley health unit; *Ruby Dunn* and *Ann Olson* from Kamloops; *Alison Neilans* from Creston, East Kootenay health unit; *Shirley Robinson* from Matsqui-Sumas-Abbotsford district; *Sybil Stuart* from Vernon, North Okanagan Valley health unit.

Zoe Ash from Surrey; *Alice Beattie*, senior epidemiology worker with Division of V.D. Control, for further study at University of Washington; *Frances (Hobden) Berry; Gladys Carruthers* from Vernon, North Okanagan Valley health unit; *Joan Davis* from Williams Lake; *Lucille Giovando* to attend University of Minnesota School of Public Health; *Mary Grierson; Janet Kennedy* from epidemiology staff, Division of V.D. Control; *Rosemarie Leier* from Keremeos; *Mary Maclean* from Gibsons; *Ann Quayle* from Saanich and South V.I. health unit; *Violet (Hele) Russell* from Campbell River; *Shirley Scanlan* from Cariboo health unit to attend U. of T.; *Marjorie Staniforth* from North Okanagan Valley health unit; *Mary Tod* from Peace River health unit.

Victorian Order of Nurses

The following are recent staff changes of the Victorian Order of Nurses for Canada:

Appointments—Calgary: *Pauline Lazo* (Calgary Gen. Hosp.). Cornwall: *Ruth Martin* (Hotel Dieu Hosp., Cornwall, and McGill University public health course). Dartmouth, N.S.: *Irene Andrews* (Ottawa Civic Hosp.) and *Dorothy Loane* (Royal Victoria Hosp., Montreal). Dundas, Ont.: *Jean Taylor* (Peterborough Civic Hosp.). Fort William: *Dorothea Cross* (McKellar Hosp., Fort William). Hamilton: *Margaret Grant* (St. Joseph's Hosp., Hamilton) and *Alva Greenslade* (St. J. H., Hamilton). Kentville, N.S.: *Evelyn Rice* (Jeffery Hale's Hosp., Quebec, and University of Manitoba p.h.n. course) as nurse in charge. Kingston: *Margaret Donevan* (Kingston Gen. Hosp.). Kitchener: *Edna Hunsperger* (Kitchener-Waterloo Hosp.). Lachine, Que.: *Cecile Vincent* (Notre Dame Hosp., Montreal). Lincoln County: *Sadie McArthur* (Kingston Gen. Hosp.). Moncton: *Mary Goodfellow* (R.V.H., Montreal, and University of British Columbia p.h.n. course). Montreal: *Elinore Hale* (Montreal Gen. Hosp.), *Jacqueline Reed* (M.G.H.), *Mary E. Shaw* (R.V.H., Montreal), and *Mary L. Shepherd* (Royal Hosp. of St. Bartholomew, London, Eng., and Health Visitor training, Royal College of Nursing). North Vancouver: *Alice Johnson* (Calgary Gen. Hosp.). North York: *Catherine Ferguson* (Walton Hosp., Liverpool, Eng., and Health Visitor cert.). Ottawa: *Patricia Allen* (Ottawa Civic Hosp.), *Elizabeth Cox* (O.C.H. and University of Toronto p.h.n. course), *Claire Doucet* (O.C.H.), *Dorothy Morrison* (Hosp. for Sick Children, Toronto, and McGill University p.h.n. course), *Lorraine Sommerville* (O.C.H.), and *Jessie Yule* (Toronto Gen. Hosp.). Owen Sound: *Donna McLeod* (Victoria Hosp., London). Peterborough: *Enid Apps* (Toronto Western Hosp.). Ste. Anne de Bellevue, Que.: *Thérèse Farmer* (Notre Dame Hosp., Montreal). Smiths Falls, Ont.: *Helen King* (Hamilton Gen. Hosp. and U. of T. p.h.n. course) as nurse in charge. Sudbury: *Madelon Gough* (Gen. & Marine Hosp., Owen Sound). Sydney, N.S.: *Edna Campbell* (St. Joseph's Hosp., Glace Bay). Timmins, Ont.: *Eileen Woodbyrne* (St. Michael's Hosp., Toronto, and U. of T. p.h.n. course). Toronto: *Barbara Hincks* (B.Sc.N., U. of T.). Welland, Ont.: *Olive Orton* (Wellgarth Nursery Training College, London, Eng.). Winnipeg: *Vivian Benson* (Grace Hosp., Winnipeg) and *Margaret Warren* (Winnipeg Gen. Hosp. and U. of Man. p.h.n. course). York Township: *Jean Abbott* (Kitchener-Waterloo Hosp.).

Re-appointments—*Helen Hobbs* as nurse in charge at Whitby, Ont.; *Margaret Janzen* to Lincoln County; *Heather Matthew* to Ottawa.

Transfers—*Anna Adams* from Cornwall, Ont., to Pictou, N.S.; *Joy Clarke* from Moncton to Barrie, Ont., as nurse in charge; *Lorna Conrad* from Amherst, N.S., to Lockeport, N.S., as nurse in charge; *Joyce Farmer* from Brantford to Sudbury; *Faye Saunders* from National Office to Saint John, N.B., as district superintendent; *Mabel Shaw* from Pictou to Moncton.

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lis Gallagher, Phyllis Jones, and *Margaret Veit* to attend University of Toronto; *Ruth Watson* to work in England.

Resignations—*Mary Ashley* and *Madolyn Burch* from Toronto, *Nita Enns* from Lincoln County, *Muriel LaFortune* as nurse in charge at Whitby, *Joan Stewart* from Huntsville—marriage; *Claire Gauthier* from Ste.

Anne de Bellevue, *Rita MacIsaac* from Ottawa, *Mary MacLeod* from Sydney, *Margaret Peace* from North York, *Ruth Russell* as nurse in charge at Barrie, Ont., *Margaret Sanderson* from Toronto, *Mrs. James Taylor* as nurse in charge at Canso, N.S., *Margaret H. Vail* from Hamilton, and *Elsie White* from Sudbury—all to take up other work; *Virginia Cline* and *Irene Lawson* to attend University of Toronto and *Letty Neaves* and *Margaret Whytock* to attend Queen's University—all from Hamilton; *Mmes M. Pearson* and *P. Soanes* from Vancouver; *Mrs. Rod Grant* as nurse in charge at Kentville, N.S.; *Margaret Kenney* as nurse in charge at New Liskeard, Ont., to work in England; *Hylda Knox* from Montreal to attend university.

Canadian Red Cross

The following are recent staff changes in the Provincial Divisions of the Canadian Red Cross Society:

New Brunswick—APPOINTMENTS: *Shirley Armstrong* (Victoria Public Hosp., Fredericton) and *Mary C. Little* (Sherbrooke Hosp., Que.) to Harvey Station; *Myrtle Brown* (Saint John Gen. Hosp.) and *Elizabeth Walsh* (St. John's Hosp.) to Plaster Rock; *Cecile Curry* (Anna Jaques Hosp.) and *Mae Harper* (Montreal Gen. Hosp.) to Rexton; *Mary B. Daly* (Saint John Gen. Hosp.) to Grand Manan; *Norma Donahue* (Hotel Dieu, Moncton) and *Roberta McAleenan* (Hotel Dieu, Moncton) to Fredericton Junction; *Ruth Weekes* (Toronto Gen. Hosp.) to Stanley.

Ontario—APPOINTMENTS: *Ida Ager* to Hornepayne; *Françoise Bourque* to Nakina; *Muriel Cheetham* and *Doris Scott* to Rainy River; *Julia Clement* and *Eleanor Tullock* to Nipigon; *Margaret Collins* to Thessalon; *Patricia Dick* to Espanola; *Bertha Edwards* and *Mary Nickel* to New Liskeard; *Helen G. Farrow, Florence Hahn, Marjory Sherk,* and *Hazel Shultz* to Wiarton; *Eleanor Gofton, Jean Harris,* and *Ruth Woolatt* to Dryden; *Wilma Lippert* to Matachewan; *Marjory McCaffery, Cynthia Penton, Irene Sellens,* and *Ruth Sharkey* to Mindemoya; *Patricia Upshall* to Bancroft; *Mildred Woodend* to Richard's Landing.

TRANSFERS: *Dorothy Chapman* from Matachewan to University of Toronto on Red Cross scholarship; *Dorothy Hall* to Dryden; *Sigrid Laine* from New Liskeard to act as "float"; *Ruth LeBarge* from Apsley to Mani-

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toulin. RESIGNATIONS: *Isabel McCormick* from Atikokan to go to the Department of Indian Affairs; *Gwen Ridley* from Emo; *Doreen Thomas* and *Beryl Rowntree* from Dryden, the latter to attend the University of Toronto; *Elsie Turner* from Wilberforce to join the Peel County health unit; *Anna Werden* from Nakina.

Saskatchewan—APPOINTMENTS: *Kay De-Marsh* from National Office, Toronto, to her home province as director, Outpost Hospitals, with headquarters in Regina; *Mmes Bagg* and *K. Boucher* to Arborfield; *Anne MacKenzie* from Galt, Ont., to Loon Lake; *M. Nowiski*, on leave from St. Michael's Hosp., Toronto, and *M. Williamson* to Hudson Bay; RESIGNATIONS: *Mrs. R. Bealoau* from Arborfield; *Mrs. C. Hoye* from Leoville.

News Notes

ALBERTA

EDMONTON

Royal Alexandra Hospital

The alumnae association entertained recently for Margaret Fraser, retiring superintendent of nurses. (See Nursing Profiles this issue.) A comfortable chair was presented to her in token of the love and esteem for her co-operation and help during her many years in the alumnae. The presentation was made by Mrs. D. Ferrier, president of the association. About 100 guests attended.

At a regular meeting of the alumnae plans were made for the annual bazaar of which Mrs. N. Richardson is convener. The meeting concluded with the showing of colored films of Sweden, Holland, Denmark, and London by Miss Chapman. I. Johnson and J. Boyd were also in Europe.

LETHBRIDGE

Madeline Larson was the guest speaker at a recent meeting of District 8. A newcomer to the city, she gave an interesting description of the Health Clinic which she is establishing here. It was reported that the Community Chest would again help the district to support the nursing registry.

A wiener roast was given by the district in honor of the 1949 graduates of Galt Hospital. Many graduates, both old and new, arrived at Henderson Lake and the event was considered a big success.

BRITISH COLUMBIA

CHILLIWACK

Mrs. G. Roberts, president, was in the chair at a recent meeting of Chilliwack

1949 INDEX

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Chapter. L. Hodgkins, former matron of the General Hospital, was given a cordial welcome on her return to the district. She thanked the members for the food parcels sent to her while in England. The members have been asked to save used clothing to send to student nurses in Germany and to vote on the question of fees as requested by the provincial office. It has been decided to send two parcels to the chapter's "adopted" child for Christmas—one to contain food and the other gift donations from the members. Mrs. D. McLean, who is leaving the district, was presented with a parting gift, accompanied by the thanks of the chapter for her staunch loyalty to the organization.

At the close of the meeting, Mr. Ed. Halsall entertained the members by an interesting talk on "English Chinaware."

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Chairman, Civil Service Commission, Victoria

CLOVERDALE

At the annual meeting of the South Fraser Chapter the following officers were elected: President, Mrs. Z. E. Ash; vice-presidents, M. Ward, Mrs. J. Keays; secretary-treasurer, A. Spence; membership and finance convener, Mrs. P. Payton; social convener, Mrs. B. McLean; press representative, Mrs. H. Carter.

Plans were completed for a rummage sale to be held at Langley Prairie. Following the business meeting, Mary Maclean gave an illustrated talk on her trip to Europe to attend the I.C.N. Conference in Stockholm. The Kodachrome slides were taken by Miss Maclean's sister.

INVERMERE

Arlet West has been appointed matron of the Lady Elizabeth Bruce Memorial Hospital, succeeding Mrs. Sam Slump who has held that position since May, 1948. Miss West is a 1944 graduate of St. Joseph's Hospital, Toronto, and has nursed in Toronto and Cranbrook.

TRANQUILLE

At a recent meeting of Kamloops-Tranquille Chapter many nurses were in attendance to hear Dr. W. D. Love's lecture on "Fundamentals of Psychiatry" which was

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very instructive. Clothing and shoes for the student nurses in Germany are being sent by the chapter.

Violet Gorham represented the chapter at the Kamloops-Okanagan district meeting held in Kelowna, accompanied by F. Primeau, Mmes R. Waugh and S. Dalgleish. Margaret Campbell, of Vancouver, told of her attendance at the I.C.N. Conference.

New officers serving on the chapter executive include: Second vice-president, D. Redding; recording secretary, M. D'Alleva; corresponding secretary, Mrs. R. Bell.

VANCOUVER

St. Paul's Hospital

One hundred and seventy-five graduates, 1941-49, attended the recent home-coming banquet to renew old times and acquaintances. Sr. Columkille welcomed them to the new addition of the nurses' home. Mrs. Murray, the president, stressed the good work done by the members and pointed out the benefits and pleasures obtained from paying $2.00 yearly. Sr. Superior donated for the occasion her beautifully decorated Feast Day Cake. Thanks are due to Mrs. Dawe and J. O'Reilly and their committee for all arrangements.

Many members have left for distant points —T. Lawton to Vernon, M. Brownlea to Toronto, G. Collier, P. Basely, M. Andrews, and B. Cowie to Portland. M. Bernhardt has returned from a trip to England, Scotland, and France.

MANITOBA

BRANDON

The Manitoba Association of Registered Nurses recently held a meeting at the Mental Hospital at the invitation of the Association of Graduate Nurses, followed by a dinner when some 125 nurses were present. The president, H. Wilson, was in the chair while the executive secretary, L. Pettigrew, read several reports and V. Leadlay, Placement Service director, told of this department's duties and aids to nurses who are registered. It is planned that a minimum Curriculum and Standard copy will be placed in each hospital so that all will have the same nursing fundamentals.

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Following the meeting, a social hour took place when many old classmates and friends renewed their friendships. C. Wedderburn, acted as hostess. At the dinner held later, served by the student nurses of the Mental Hospital, I. McDiarmid, W. Barrett, and I. Barton, who attended the I.C.N. Conference, were guest speakers. Their talks included descriptions of the English Derby, English plays, historical sites such as mounds of the Vikings, castles, trooping of the colors, and much pertaining to nursing and nursing institutes.

Several social functions and presentations were accorded Caroline (Wedderburn) Hutchison prior to her marriage. Formerly matron of the Mental Hospital and past president of the B.A.G.N., she now resides in Dryden, Ont.

At a regular meeting of the B.A.G.N., Mrs. Ethel Griffin, the president, was in the chair. The success of the Married Nurses Tea was noted and Mrs. Peirce voted a sum for overseas Christmas parcels. A report from E. Cranna, scholarship convener, was read by N. Crighton. Plans are being made by Mrs. R. Russell for a dance in aid of this fund. A vote of thanks was given to Mrs. Lewis and students of the General and Mental hospitals and friends for their co-operation in tagging for the Cancer Relief Fund. Alice Bennett is now vice-president of the association.

CARMAN

Hazel Naudett, formerly superintendent of Pontiac Community Hospital, Shawville, Que., now holds a position at the Memorial Hospital.

KILLARNEY

Sarah Nicholls, formerly with Virden Hospital, is now matron of the General Hospital. Mrs. Nicholls, who came to Canada in December, 1947, is a graduate of Guy's Hospital, London, Eng. Becoming a State Registered Nurse in February, 1935, she did post-graduate work at Guy's for two years as surgical ward sister, staff midwife, and operating-room nurse. She was also technical nursing officer to the Ministry of Labor until coming to Canada.

Mrs. Nicholls succeeds Margaret Kanes who had been matron since the opening of the hospital about a year ago.

WINNIPEG

Children's Hospital

At the annual meeting of the alumnae association Mrs. Anne Templeton was elected president. The recording and corresponding secretaries are S. Austin and B. Davis. Those serving on the various committees include: Mmes C. Mitchell, C. E. Barber, C. Walch, H. Brown, J. Moore, and F. Prest.

NEW BRUNSWICK

SAINT JOHN

B. Selfridge, the vice-president, was

in the chair at the first meeting of Saint John Chapter for the 1949-50 season when K. Lawson gave a report on the provincial annual meeting held at Edmundston.

General Hospital

Miss Selfridge, the president, presided at a meeting of the alumnae association when letters were read from English nurses, expressing their appreciation on the receipt of parcels. A collection was taken to send additional packages overseas with M. Murdoch in charge. A shower of food parcels was planned for a later meeting. Elfreda Kukainis, a native of Latvia and physical director of the local Y.W.C.A., told the members something of her native country.

The following graduates are on the staff of King Edward VII Memorial Hospital, Bermuda, for the winter: Misses Diggle, Doherty, Mowry, McWilliam, Wade.

St. Joseph's Hospital

Marie Wallace was in the chair at a meeting of the alumnae association when a Bring and Buy Sale was conducted. It was reported that a box had been sent to the alumnae's "adopted" English family. M. Parsons was in charge of the social hour which followed when musical selections were contributed by F. Wallace.

At the 15th annual meeting of the American College of Hospital Administrators held in Cleveland, Rev. Sr. Mary Veronica, administrator of the hospital, was elected a Fellow in the college, which is an international professional organization of hospital administrators. Sr. Veronica was the only Canadian to receive a fellowship. She entered the Sisters of Charity in 1898 and served as superintendent of the hospital here for two terms—from 1928 to 1934 and from 1942 to 1948. Prior to her appointment to St. Joseph's, Sr. Veronica served at Holy Family Hospital, Prince Albert, Sask., for eight years. A councillor in the general administration of the Sisters of Charity Community, she is an associate member of the Canadian Medical Record Librarians as well as a member of the American Association of Record Librarians.

NOVA SCOTIA

HALIFAX

Margaret Blandford has been appointed by the Public Health and Welfare Committee to the x-ray department of the Tuberculosis Hospital, replacing Ruth MacKay. Miss Blandford is a registered laboratory and x-ray technician.

ONTARIO

DISTRICT 1

SARNIA

Madalene Baker, registry adviser, Registered Nurses Association of Ontario, recently addressed the executive and registry committee of the local Community Nursing Registry at a dinner meeting. Miss Baker is being loaned by the R.N.A.O. to the province of P.E.I. to assist in setting up the new system of licensing for nurses. Also in attendance were Deby Hooper, president of the board of directors of the registry, and Mrs. R. D. Harris, registrar.

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Dorothy Hollister has been appointed assistant administrator of the General Hospital to succeed Mildred Weir. Miss Weir has left after five years' service to engage in post-graduate work in hospital administration at McGill University. Miss Hollister, a native of Brockville, is a graduate of the Toronto Hospital for Sick Children and has done post-graduate work at Women's College Hospital, Toronto. For the past two years she has been superintendent of the obstetrical department at S.G.H.

Districts 2 and 3

Brantford

A graduate of the General Hospital, Ann MacKenzie is now at Loon Lake, a small community 75 miles north of North Battleford, Sask., on the staff of a Red Cross outpost hospital. Planning to stay for a year, she intends to spend some of her spare time oil painting. Miss MacKenzie has done water colors but this will be her first adventure in oils, and she expects the wilds of the Canadian North to provide her with ample painting material.

District 5

Barrie

Approximately 175 members attended the fall meeting of District 5. The chairman, Elizabeth Bregg, conducted the afternoon session when reports of committees were presented for acceptance. Members were sorry to hear of the resignation of Nettie Fidler as R.N.A.O. president. Olive Wasley, student nurse at the Toronto Western Hospital, gave an interesting outline of her experiences while attending the I.C.N. Conference in Stockholm.

The Barrie Chapter was hostess at the dinner meeting when Ethel Cryderman, director of the V.O.N. in Toronto and C.N.A. president, gave a comprehensive picture of the Stockholm conference.

Toronto

St. Michael's Hospital

In conjunction with the Quarrington Concert Bureau, the alumnae association recently sponsored a musical evening in Massey Hall, the guest artiste being Sheila Munro.

The home of Gladys Hall was the scene of a reunion of the Class of 1929. The guest of honor was Mae (MacNeill) Stenhouse. She has returned to Canada for the first time since graduation, having spent some time in Scotland and recently in New Zealand. Her husband is on the staff of the Sask. Mental Hospital, Weyburn. Those present included: A. Hickey, M. Blois, K. Gropp, G. MacDuff, J. Snell, A. Romano, I. Brooks, E. Regan, A. Atkinson, F. MacDuff, A. O'Connell, M. Farie.

The Class of 1944 held a reunion at the home of Isabel Knox in Cooksville. Letters from classmates unable to attend were read with pleasure. Among those present were: I.

Bart, M. Comartin, G. Robinson, M. Doherty, M. Wetmore, M. Griffin, J. Heffernan, A. Kramer, K. Kirwin, E. Graham, G. McCarthy, K. McDonald, N. McHenry, B. O'Neill, R. Powell, F. Adams, K. Pecore.

Sr. Marie Antoinette is in charge of the emergency and out-patient department at St. Joseph's Hospital, Toronto, while Sr. Florecita is in charge of a floor at the same hospital. C. Bond is now a nursing counsellor with the Department of National Health and Welfare, Ottawa. S. Devlin is with the T.C.A. J. Pegler is with the V.O.N. Doreen Murphy has been transferred to Parkdale district from S.M.H. health service. L. Larson has been transferred from the Peterborough health unit to the unit at Porcupine as senior nurse. J. Hope is with the St. Elizabeth Visiting Nurses. B. Grant, upon completion of an advanced nursing course at university, has returned to the nursing staff of the Toronto Department of Public Health. Betty Burns is on the staff of a small outpost hospital near Tokyo, Japan.

Sr. St. Nilus is at the convent at Colgan, Ont. J. LoPresti has entered the Maryknoll Sisters. A Buckley, who has entered the Novitiate of the Grey Nuns of the Immaculate Conception, Pembroke, is now Sr. Mary Francis. T. Morrissey is also there and is now Sr. Mary Edward.

The following graduates are doing post-graduate work at various universities as noted: Toronto—E. Byrnne, N. Gleeson, L. Hartman, T. M. Kelly, M. J. Laviolette, R. M. Osteck, M. Paus, A. M. Quigley, Srs. Carmichael and Hedwig; McGill—M. MacIntosh; Ottawa—M. Tanney; St. Francis Xavier—A. Decoste and T. Rooney; St. Louis—P. Bradford and E. Colgan (alumnae scholarship winner); Columbia—B. K. Webster.

District 9

North Bay

At a recent executive meeting of the district, there were delegates present from all five chapters. Sr. Camillus, chairman of the hostess chapter, welcomed them to St. Joseph's Hospital where the afternoon and evening sessions were held. The former was devoted to a discussion of financial problems, under the leadership of the secretary-treasurer, Mrs. H. G. McLean.

The evening session included discussion on: Bursaries for student nurses; use of the R.N.A.O. *News Bulletin* and *The Canadian Nurse* at chapter meetings; stimulation of interest in chapter meetings; use of registries; Ontario Nursing Act; proposed change in R.N.A.O. fee; problems of sections; Continental Casualty Co. insurance plan; overseas parcels for British nurses; plans for 1950 annual meeting.

It was with regret that members learned that their chairman, Mrs. I. Gleason, is leaving the district. Lois Smith, who is succeeding her, was welcomed by the delegates and a vote of thanks tendered to Mrs. Gleason for her able and interested leadership during her term of office.

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By Nettie D. Fidler and Kenneth G. Gray. An authoritative book which makes clear the nurse's legal position. Every nurse should be familiar with this information. A copy of the book will prove invaluable in the nursing library. "This valuable little book."—*The Canadian Nurse.* 112 pages, 1947. $2.00.

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By K. A. Baird. "A useful text for student nurses and might also be owned with advantage by public health nurses who see skin conditions, with even more frequency, in the community."—*The Canadian Nurse.* 83 pages, 11 full-page illustrations. 1947. $2.00.

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District 10

Fort William

The life of a missionary among the Mohammedans of French West Africa is the road Joan Jackson, of Reserve, Sask., plans to follow. A 1938 graduate of McKellar General Hospital, she studied at the University of Toronto School of Nursing for a year and returned to her home hospital as clinical supervisor until three years ago. In 1946, Miss Jackson entered the Baptist Seminary in Toronto, studying Bible training and French, among other subjects, to qualify for a position as missionary. After a six-month French course in Paris, she will study the Hausa language at a school in Minna, Nigeria, before proceeding to her station for a four-year period. At the end of that time Miss Jackson will receive a furlough, but she expects to return to the African field and "make it my life's work."

Besides preaching the gospel among the Mohammedans, she will use her nurse's training in connection with leper work and may possibly be stationed in a hospital which is being contemplated for that area.

QUEBEC

Quebec City

Jeffery Hale's Hospital

A miscellaneous shower was recently held for M. Fischer who has accepted a position as industrial nurse with Donnacona Paper Mill, Que. A. MacDonald succeeds Miss Fischer as treasurer of the alumnae association. The following nurses are on the general duty staff: Misses Anderson, Bancroft, Gray, MacLeod, Ronalds, Watt. Miss Parker has resigned to be married. Mrs. D. Firth has replaced N. MacIntosh in the out-patient department.

SASKATCHEWAN

Prince Albert

At a recent meeting of Prince Albert Chapter, a large attendance welcomed the report of the I.C.N. Conference given by Agnes Campbell. It was decided to continue with the cod liver oil program which has been conducted in the past.

Recent additions to Victoria Hospital staff include: T. Arngrimson, J. Thompson, G. Cameron, and L. Peterson. C. (Muir) McKay has resigned from the staff of Holy Family Hospital. J. Goward is with the V.O.N.

Regina

General Hospital

The official opening of the new wing of the hospital recently took place. The total bed capacity is now 850. New members on the staff include: V. Antonini, pediatric teaching supervisor; M. Baxter, Red Cross division, new wing; M. Humphreys, clinical surgical supervisor. L. Garland has been

awarded a provincial bursary and is attending the University of Western Ontario to complete her B.Sc.N. course.

Grey Nuns' Hospital

The fall class recently admitted numbered 55. New appointments to the staff include: N. Street, nursing arts instructor; F. Hummason, science instructor; M. Howell, health nurse. Also on the staff are: G. Howell, E. Borys, D. Mario, M. Carr, G. Carlson, Mmes E. Stubbins and G. Christie. Resignations include: J. Purvis, Y. Nishimura, I. Brown, Mmes F. Appenheimer, D. Wellington, A. Maier; G. Spice (science instructor) to teach in Tennessee; M. Findlay (cancer clinic) to be married. Rev. Sr. Hamon, O.R. supervisor, has returned from taking a course in Montreal. E. Jefferson, surgical clinical instructor, has left for St. Louis to complete a course leading to the B.Sc. degree.

SASKATOON

City Hospital

A candlelight ceremony for the capping of 40 students of the 1952 class recently took place. Recent additions to the staff include: H. Halliday, R. McDonald, F. McCallum, J. Spark, D. Bourne, and A. Woolf—all S.C.H. graduates. G. James is now science instructor, replacing Miss Salte, while F. Dean succeeds H. Berry as health director. V. Halen, L. Jammaers, and Mrs. McKitrick have also been added to the staff. D. Bell and J. Bayers are taking a course in O.R. technique at Vancouver General Hospital. Miss Bell was a recipient of the scholarship donated by the medical staff of S.C.H.

St. Paul's Hospital

Forty-two new students, including two Grey Nuns—Srs. Bourgeois and Desmarais—were recently welcomed to the hospital. Sr. A. Lachance, sister superior, is congratulated on becoming a member of the American College of Hospital Administrators. The following graduates are now on the staff: G. Johnson, J. Lys, R. Kinash, A. Jasieniuk, R. Tumback, D. Moss, C. Roy. Additional staff members include: Mrs. Kurtz, assistant dietitian; H. Onishenko, A. Cameron, M. Gross, Mrs. Trepanier. F. Kelm, recipient of a government bursary, is taking a public health course.

Saskatoon Sanatorium

The following have joined the staff: S. Thomas, R. Walper, L. Beaton, and D. Birch as head nurse, surgical ward. Resignations include: M. Corbett, H. Montgomery, K. Dyck, A. Dawson, and T. Fitzgerald.

WADENA

Lena Krotenko has been appointed matron of the Union Hospital, succeeding Mrs. M. Runions who has left for Regina. The resignations of Mrs. V. Reid and Shirley Peterson have been accepted.

Many nurses and doctors, too, as well as persons in all walks of life owe a debt of gratitude to Baby's Own Tablets for the comfort these simple triturates brought to their own babyhood upsets. Yes, over half a century of successful use have proved the dependability of Baby's Own Tablets for relief of constipation, digestive upsets, teething troubles and other minor ills.

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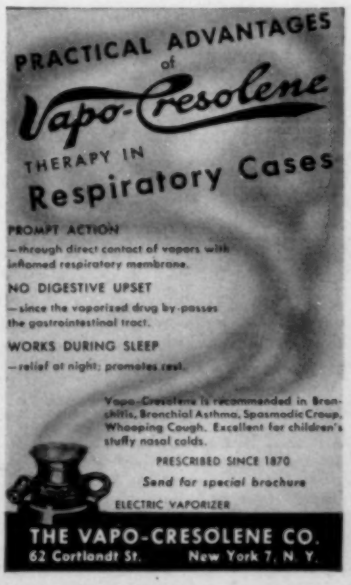
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Supervisor for Pediatric Division of 130-bed hospital. Salary: $190 gross. Apply, stating qualifications, in c/o Box 25, The Canadian Nurse, Ste. 522, 1538 Sherbrooke St. W., Montreal 25, Que.

Supt. of Nurses & Principal of School of Nursing for Royal Alexandra Hospital, Edmonton, Alta. Submit complete statement regarding qualifications & salary expected to Dr. D. R. Easton, Medical Supt.

Nursing Arts Instructor & Educational Director immediately. The hospital, located in capital city, is connected with large clinic & college which aids greatly in teaching students. Apply Director of Nurses, Evangelical Hospital, 6th & Thayer, Bismarck, North Dakota.

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O.R. Supervisor for 275-bed well-equipped modern hospital, with Nursing School, in picturesque lakehead country. Blue Cross Hospital plan. 1 mo. yearly vacation with pay. Apply, stating salary expected, Director of Nursing, General Hospital, Port Arthur, Ont.

Operating-Room Nurses immediately. Excellent working & living conditions. For further particulars write Supt. of Nurses, Toronto Hospital for Tuberculosis, Weston, Ont.

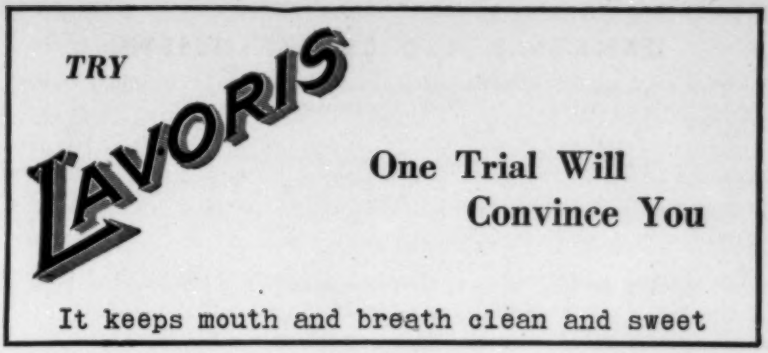
Asst. Night Supervisor for Toronto Hospital for the Treatment of Tuberculosis, Weston, Ont. Apply, stating experience & qualifications, to Director of Nursing Services.

Vancouver General Hospital requires: **Clinical Instructor in Medical Nursing & General Staff Nurses.** Salary: $172 gross, including current Cost of Living Bonus. Extra premium for evening or night duty. Registration in British Columbia required. For further information apply Director of Nursing, General Hospital, Vancouver, B.C.

Registered Nurses for 250-bed approved hospital. 40-hr. wk. Salary: $200 base pay. Additional $20 for evening duty & $10 for nights. $5.00 increase every 6 mos. until $50. 1 mo. paid vacation per yr. Write Director, Nursing Service, St. Elizabeth Hospital, Yakima, Washington.

Graduate Nurses for permanent General Duty in 500-bed hospital. Salary: $175 per mo. with annual increments of $7.50 per mo. for 4 yrs. 28 days vacation; all statutory holidays granted. 44-hr. wk. Superannuation. Sick leave benefits. Apply Director of Nursing, Royal Jubilee Hospital, Victoria, B.C.

General Duty Nurses (2) immediately for 15-bed hospital. Salary: $125 per mo. with full maintenance. Apply Sec.-Treas., Municipal Hospital, Magrath, Alta.



Graduate Dietitian at Ontario Hospitals in Kingston, Whitby, Woodstock. Initial salary: $2,140 per annum plus $180 Cost of Living Bonus, less perquisites ($26.50 for room, board, laundry). Annual increment, accumulative sick leave, superannuation, 3 wks. vacation, statutory holidays & special holidays with pay. 8-hr. day, 6-day wk. Apply Supt. at above hospitals.

Registered Nurses for General Staff at Ontario Hospitals in Brockville, Hamilton, Kingston, London, New Toronto, Orillia, St. Thomas, Toronto, Whitby, Woodstock & Toronto Psychiatric Hospital. Initial salary: $1,840 per annum plus $180 Cost of Living Bonus, less perquisites ($26.50 for room, board, laundry). Annual increment, accumulative sick leave, superannuation, 3 wks. vacation, statutory holidays & special holidays with pay. 8-hr. day, 6-day wk. Apply Supt. of Nurses at above hospitals.

Graduate Nurses for General Floor Duty. Salary: $115 per mo. Full maintenance & laundry. $60 yearly increase up to 3 yrs. Apply, stating qualifications, Supt., Brome-Missisquoi-Perkins Hospital, Sweetsburg, Que.

General Staff Nurses for General Hospital, Hamilton, Ont. Initial gross salary: $38 per wk. plus laundry. 44-hr. wk., rotating service. Opportunities for promotion to staff appointments at higher salaries for qualified experienced **Operating-Room Nurses & Obstetrical Nurses.** For further information apply Director of Nursing.

General Duty Nurses for 350-bed Tuberculosis Hospital in centre of Laurentian summer & winter resort area, 2 hrs. from Montreal. Starting salary: $115 per mo. plus full maintenance. Attractive working hrs. with 1½ days off weekly & 1 week-end ea. mo. 1 mo. annual vacation. 14 days sick leave. Apply Supt. of Nurses, Royal Edward Laurentian Hospital, Ste. Agathe des Monts, Que.

General Duty Nurses. 8-hr. broken day. 48-hr. wk. Gross salary: $163.40 monthly. All salaries have scheduled rate of increase. Cumulative sick leave. Pension plan in force. Blue Cross plan. 3 wks. holiday after 1 yr. service. Apply Supt. of Nurses, Muskoka Hospital for Tuberculosis, Gravenhurst, Ont.

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Operating-Room Nurse, preferably with post-graduate training, though not essential. All-graduate staff. 8-hr. day, 5½ day wk. Apply Director of Nursing, Children's Memorial Hospital, Montreal 25, Que.

Staff Nurse for **Men's Medical Ward.** Also one for **Communicable Disease Ward.** Apply Supt. of Nurses, Royal Alexandra Hospital, Edmonton, Alta.

Graduate Nurse (male or female) for Ontario Government Institution—small, modern hospital, well equipped. Ward, Clinical & Operating-Room duties. Best of references required. Housing available for married man. Provincial Civil Service Appointment. Apply in writing to Supt., Industrial Farm, Burwash, Ont.

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Registered Nurses for General Staff Duty for the Division of Tuberculosis Control required by British Columbia Civil Service—***Vancouver Unit:*** 225-bed T.B. Hospital, located at 2647 Willow St., Vancouver. All major services & student affiliation course. Registration in B. C. required. *Gross salary:* $182 per mo. Annual increments of $60 (over 5-yr. period). No residence accommodation. ***Tranquille Unit:*** 350-bed T.B. Hospital, located 12 miles from Kamloops in southern interior. All major services except student affiliation. *Gross salary:* $188.50 per mo. Annual increments of $60 (over 5-yr. period). New modern residence; attractive bed-sitting-rooms; recreational facilities. Maintenance deduction: Room $5.00, laundry $2.50. Excellent food at 20 cts. per meal. ***Conditions—Both Units:*** 8-hr. day, 5½-day wk. Rotating shifts. 4 wks. annual vacation with pay plus 11 statutory holidays. Sick leave 20 days per yr.—14 cumulative. Promotional opportunities. Superannuation. Write for information & applications to Supt. of Nurses of respective Units or to Director of Nursing, Division of T.B. Control, 2647 Willow St., Vancouver, B.C.

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Instructor for course in Basic Nursing (Clinical & Classroom) for University of Toronto School of Nursing. Apply to Secretary of School at 7 Queen's Park, Toronto 5, Ont.

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Post-graduate course in Pediatrics required. Registration in British Columbia essential. 44-hr. wk. 28 days' vacation after 1 yr. service. 1½ days' sick leave per mo. accumulative. **Basic Salary:** $202.50. Apply to hospital.

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QUEBEC

The Association of Nurses of the Province of Quebec

The Association of Nurses of the Province of Quebec, created by Licensing Act, April 17, 1946, replacing The Registered Nurses Association of the Province of Quebec, Incorporated February 14, 1920.

Pres., Rév. Sr. Valérie de la Sagesse; Vice-Pres. (*Eng.*), Misses M. S. Mathewson, C.V. Barrett; Vice-Pres. (*Fr.*), Mlles F. Verret, B. Laliberté; Hon. Sec., Rev. Sr. M. Felicitas; Hon. Treas., Mlle A. Martineau; *Councillors*, Mme M. A. Flynn, Mlles C. Demers, R. Aubin, M. Bissonnet, G. Beauregard. The above constitute the *Executive Council* & are Members of the *Committee of Management*, together with: Mme P. Morency, Rév. Srs. F. Agnès, St. Ferdinand, Allard, Rheault, Rév. Mère Marie-Paul, Misses A. Trudel, J. Gagnon, L. Couet, A. Peverley, M. Flander, B. Bourbonnais. *Advisory Board*, Misses E. C. Flanagan, G. M. Hall, F. Munroe, M. E. Lunam, S. Soles, Mrs. J. Green, Rév. Srs. Paul du Sacré-Coeur, Thomas du Sauveur, Louise de Marillac. *Committee Chairmen: Institutional Nursing* (*Eng.*), Miss N. Mackenzie, General Hospital, Montreal 18; (*Fr.*), Rév. Sr. Denise Lefebvre, Institut Marguerite d'Youville, Montréal 25; *Public Health* (*Eng.*), Miss E. Pibus, 12 Amesbury Ave., Montreal 25; (*Fr.*), Mlle E. Merleau, 5302 ave Victoria, App. 2, Montréal 26; *Private Duty* (*Eng.*), Mrs. E. M. Griffith, 3660 Lorne Cres., Apt. 5, Montreal 18; (*Fr.*), Mlle J. Côté, 3622 rue St. Denis, App. 1, Montréal 18. *Chairmen, Board of Examiners:* (*Eng.*), Mrs. S. Townsend, 570 Chester Rd., Town of Mt. Royal, Mtl 16; (*Fr.*), Mlle J. Trudel, Hôpital Ste. Justine, Montréal 10. Sec.-Registrar, Miss Margaret M. Street. Visitor to Fr. Schools of Nursing, Mlle S. Giroux. **Association Headquarters, 504-6 Medical Arts Bldg., Montreal 25.**

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NEW BRUNSWICK

A.A., Hotel Dieu Hospital, Campbellton

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A.A., Saint John General Hospital

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A.A., L. P. Fisher Memorial Hospital, Woodstock

Pres., Mrs. William Adair, Main St.; Vice-Pres., Mrs. W. B. Manzer, Chapel St.; Sec.-Treas., Mrs. Percy Colwell, Main St.; *Executive Committee:* Mrs. King, Broadway; Mrs. A. Peabody, Woodstock; Mrs. Arnold, Elm St.

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A.A., Nova Scotia Hospital, Dartmouth

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A.A., Halifax Infirmary

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A.A., Victoria General Hospital, Halifax

Pres., Mrs. G. M. Morrell, 54 Russell St.; Vice-Pres. Mrs. J. M. Cameron, 34 Drummond Crt.; Sec., Miss Mary Gunn, V.G.H.; Treas., Mrs. Charles Hodgson, 15 Duncan St.

A.A., Aberdeen Hospital, New Glasgow

Hon. Pres., Miss Nina Grant; Pres., Mrs. Vernon MacDonald; Sec., Miss Annie Saunders; Treas., Miss Jessie McLaughlin, A.H.; *Rep.* to *Press*, Mrs. MacG. MacLeod.

A.A., City Hospital, Sydney

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ONTARIO

A.A., Belleville General Hospital

Hon. Pres., Miss A. D. Potts; Pres., Miss J. Bailey; Vice-Pres., Miss M. Pigden; Sec., Mrs. A. Smith, 181 B. Dundas St. E.; Treas., Miss R. Wilie; *Committees: Gift*, Miss D. Platt; *Social*, Misses E. Hutchinson, H. Jones; *Program*, Mrs. D. Bass, Miss E. Jose; *Nominating*, Mrs. G. Whitney; *Reps.* to: *V.O.N.*, Mrs. Clapp; *The Canadian Nurse*, Miss M. Taylor.

A.A., Brantford General Hospital

Hon. Pres., Miss J. M. Wilson; Pres., Miss M. Patterson; Vice-Pres., Miss M. Terryberry, Mrs. G. Brittain; Sec., Mrs. L. Sheppard; Treas., Miss Alice Riddle; *Committees: Gift*, Misses J. Weir, M. Southward; *Flower*, Misses D. Rashleigh, T. Kett; *Social*, Miss A. McKenzie, Mrs. D. Habberjam; *Reps.* to: *Local Council of Women*, Mrs. C. Andrews; *Council of Social Agencies*, Miss J. Hankinson; *The Canadian Nurse & Press*, Miss Ailsa Scott.

A.A., Brockville General Hospital

Hon. Pres., Misses A. Shannette, E. A. Moffatt; Pres., Mrs. D. Cooke; Vice-Pres., Miss H. Corbett, Mrs. H. Greene; Sec., Mrs. H. L. Bishop, 89 King St. ..; Treas., Miss M. Gardiner; *Committees: Social*, Misses L. Merkley, D. MacMillan; *Gift*, Miss V. Kendrick; *Property*, Mrs. Greene, Misses E. Thorpe, R. Carbery; *Fees*, Miss V. Preston; *Plan for Hosp. Care*, Mrs. C. Babcock; *Rep.* to *Press*, Miss D. Barrett.

A.A., Ontario Hospital, Brockville

Hon. Pres., Mrs. E. M. Orr; Pres., Miss K. Hinton; Vice-Pres., Mmes B. Smith, O. Belfoi; Sec., Mrs. O. Adams, 43 Charles St.; Treas., Miss M. Holley; *Committees: Social*, Mmes F. Hamblen, J. Lynch, Miss G. Best; *Welfare*, Mmes M. Glover, G. Haggerty, Miss J. Flood; *Membership*, Mmes J. Gaffney, C. Jenkins, M. Fairbourne; *Rep.* to *Press*, Mrs. E. Wilkins.

A.A., Public General Hospital, Chatham

Hon. Pres., Miss P. Campbell; Pres., Mrs. A. E. Harrison; Vice-Pres., Misses E. Stenton, R. Judd; Rec. Sec., Mrs. R. G. Stoehr; Corr. Sec., Mrs. G. Brisley, 29 Prince St. N.; Treas., Miss M. Gilbert; *Rep.* to *The Canadian Nurse*, Miss E. Orr.

A.A., St. Joseph's Hospital, Chatham

Hon. Pres., Rev. Mother M. Fabian; Hon. Vice-Pres., Rev. Sr. M. Georgina; Pres., Mrs. M. Hickey; Vice-Pres., Miss D. Nash, Mrs. C. Salmon; Rec. Sec., Miss A. Coveny; Corr. Sec., Miss A. Kenny, 258 Queen St.; Treas., Miss D. Carley; *Councillors*, Mmes H. McPherson, J. Embree, M. Millen, Miss L. Pettypiece; *Committees: Buying*, Miss P. Tunstall, Mrs. P. Doyle; *Lunch*, Mmes I. Mulhern, L. Smyth, M. O'Rourke; *Program*, Misses D. Marini, M. Boyle, M. Doyle, J. Laprise; *Reps.* to: *Blue Cross*, Miss Boyle; *Press*, Mrs. Salmon; *The Canadian Nurse*, Mrs. M. Jackson.

A.A., Cornwall General Hospital

Hon. Member, Mrs. Boldick; Hon. Pres., Miss Nephew, Mrs. H. Gunther; Pres., Miss E. McIntyre; Vice-Pres., Miss M. Ferguson, Mrs. H. Quart; Sec., Mrs. V. S. Whaley; Treas., Miss M. Clark; *Committee Conveners: Flowers & Gifts*, Miss E. Allen; *Social & Program*, Miss E. Paul; *Membership*, Miss R. Warren; *Reps.* to: *Press*, Mrs. P. Robertson; *The Canadian Nurse*, Mrs. E. Gunther.

A.A., Hotel Dieu Hospital, Cornwall

Hon. Pres., Rev. Sr. Daniels; Pres., Miss U. Leblanc; Vice-Pres., Rev. Sr. Mooney; Sec.-Treas., Miss Alice Huot, H.D.H.; Corr. Sec., Miss H. Fraser; *Committee Conveners: Social*, Miss R. McDonald; *Publicity*, Miss T. Wheeler; *Gift*, Miss D. Ryan.

A.A., McKellar Hospital, Fort William

Hon. Pres., Miss O. Waterman; Pres., Mrs. C. Orton; Vice-Pres., Mrs. B. Strachan; Sec., Mrs. H. Samson; Corr. Sec., Miss A. McCuaig, McK. G. H.; Treas., Mrs. D. Poulter, 549 Empire Ave.; *Council*, Mmes Bolt, Higginbottom, Marlatt, Payette, Wallace.

A.A., Galt Hospital

Hon. Pres., Miss Sewell; Pres., Miss Teather; Vice-Pres., Mrs. D. Schoenfeld; Sec., Miss Park; Treas., Mrs. E. D. Scott, 65 Harris St.; *Committee Conveners: Flowers & Gifts*, Miss Cole; *Social*, Mrs. R. Park; *Rep.* to *Press*, Miss Blagden.

A.A., Guelph General Hospital

Hon. Pres., Miss S. A. Campbell; Past Pres., Mrs. F. C. McLeod; Pres., Miss Meryl McFee; Sec., Mrs. C. Gawsden, 240 Woolwich St.; Treas., Miss C. S. Ziegler, 48 Delhi St.; *Committee Conveners: Program*, Miss F. Mortimer; *Social*, Mrs. F. C. McLeod; *Card*, Miss E. Stewart; *Scholarship*, Miss K. Cleghorn.

A.A., St. Joseph's Hospital, Guelph

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A.A., Hamilton General Hospital

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A.A., Ontario Hospital, Hamilton

Hon. Pres., Miss K. E. Turney; Pres., Miss A. A. Busch; Vice-Pres., Mrs. M. Clark; Sec., Miss N. Parker, O.H.; Treas., Miss L. Angle; *Committees: Social*, Mrs. R. Chappelle, Misses M. Moffatt, M. McConesky, M. Carrigan, J. Etherington; *Visiting*, Misses J. Balsam, M. Seeman; *Rep.* to *Press*, Miss D. Campbell.

A.A., St. Joseph's Hospital, Hamilton

Hon. Pres., Sr. M. Geraldine; Hon. Vice-Pres., Sr. M. Ursula; Pres., Mrs. Bert Markle; Vice-Pres., Miss E. Quinn, Mrs. J. Tilden; Sec., Miss B. Clohecy, 61 E. Ave. S.; Treas., Miss N. Hinks; *Committees: Executive*, Misses A. McCowell, N. Walsh, M. Reding, Mrs. R. C. Wheatley; *Social*, Miss A. Payne; *Publicity*, Miss D. Rilett; *Reps.* to: *R.N.A.O.*, Miss E. Freeman; *The Canadian Nurse*, Miss A. McNamara.

A.A., Kingston General Hospital

Hon. Pres., Miss L. D. Acton; Pres., Miss L. Smith; Vice-Pres., Mmes E. Potter, C. J. Cornwall; Sec., Miss H. Carnegie, K.G.H.; Asst. Sec., Miss H. Blue; Treas., Mrs. G. Hunt; Asst. Treas., Miss O. Wilson; *Committee Conveners: Flower*, Mrs. S. Smith; *Private Duty*, Mrs. C. Jackson; *Program*, Mrs. M. Atack; *Reps.* to: *Local Council of Women*, Mrs. Leggett; *Kingston Film Council*, Mrs. Spence.

A.A., St. Mary's Hospital, Kitchener

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A.A., Ross Memorial Hospital, Lindsay

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A.A., Ontario Hospital, London

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A.A., St. Joseph's Hospital, London

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A.A., Victoria Hospital, London

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A.A., Ottawa General Hospital

Hon. Pres., Rev. Sr. M. Alban; Pres., Mme Noël Chassé; Vice-Pres., Mrs. D. Kipp, Miss M. Gormley; Sec., Miss R. MacIsaac, 286 Nelson St.; Treas., Miss F. Brind'Amour; Membership Sec., Rev. Sr. Helen of Rome (Assts., Misses D. Finlan, M. Boutin); *Councillors*, Mmes J. A. Lecours, R. Seguin, Misses J. Frappier, M. Bambrick, T. Hurtubise, P. Manthe.

A.A., St. Luke's Hospital, Ottawa

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A.A., Owen Sound General and Marine Hospital

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A.A., Peterborough Civic Hospital

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A.A., St. Joseph's General Hospital, Port Arthur

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A.A., Sarnia General Hospital

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A.A., Mack Training School, St. Catharines

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A.A., St. Thomas Memorial Hospital

Hon. Pres., Miss I. Stewart; Pres., Mrs. C. Clark; Vice-Pres., Mrs. D. Higgs; Sec., Miss A. Claypole, M.H.; Corr. Sec., Miss Etta Dodds, 33 Wellington St.; Treas., Mrs. J. Graves; *Rep.* to *The Canadian Nurse*, Miss Dodds.

A.A., The Grant Macdonald Training School for Nurses, Toronto

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A.A., Riverdale Hospital, Toronto

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A.A., St. John's Hospital, Toronto

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A.A., St. Michael's Hospital, Toronto

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A.A., School of Nursing, University of Toronto

Hon. Pres., Miss E. K. Russell; Hon. Vice-Pres., Miss F. H. M. Emory; Past Pres., Miss Elvira Manning; Pres., Miss Helen Carpenter; First Vice-Pres., Miss Edith Dick; Sec. Vice-Pres., Miss Eileen Cryderman; Sec.-Treas., Mrs. Charles Querrie, 23 Marmaduke Ave.

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A.A., Training School for Nurses of the Toronto East General Hospital with which is incorporated the Toronto Orthopedic Hospital

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A.A., Toronto Western Hospital

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A.A., Wellesley Hospital, Toronto

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A.A., Women's College Hospital, Toronto

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A.A., Ontario Hospital, New Toronto

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A.A., Connaught Training School for Nurses Toronto Hospital for Tuberculosis, Weston

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A.A., Hôtel-Dieu Hospital, Windsor

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A.A., Woodstock General Hospital

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QUEBEC

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Pres., Miss Ruby Goodfellow; Vice-Pres., Miss Myrtle Gleason; Sec.-Treas., Mrs. Byrtha Jobber, 105-51st Ave., Dixie, Montreal 32; *General Nursing Representative*, Miss Ruby Goodfellow; *Executive Committee*, Mrs. Barlow, Mrs. Gaw, Miss Dewar.

A.A., Children's Memorial Hospital, Montreal

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